

Analysis of the demand: contributing to a unified clinical approach.

by Nicolò Gaj*

Towards the end of their university studies, most psychology students admit that they do not know exactly what a psychologist does in practice and what requests from society the professional psychologist has to answer. Psychology students often begin their studies with a clear vision in mind of what they think are the main applications of psychology but after several years studying, these certainties start to totter. It seems that the great wealth of information collected during their studies adds to their confusion: the closer they are to the goal of the working in the profession, the unclearer the traits of the profession become. In my opinion, one of the reasons for this is the immaterial nature of psychological services (Olivetti Manoukian, 1998); this is not a characteristic peculiar to “psych” services, but to all types of services. The service field, in fact, has some peculiar characteristics compared to the domain of goods production (Normann, 1984):

- unlike the case of tangible goods, there is no transfer of ownership when one buys;
- the product cannot be shown and does not exist before purchase;
- the product cannot be stored;
- the production, the consumption and the sale take place in the same place;
- the buyer/client participates directly in the production;
- it is almost always necessary for the service provider and the client to have direct contact;
- the service cannot be exported, but the system of providing the service can;

What can be called the “immateriality” of psychological services may lead to them being considered difficult to assess using the tools of reason, or on the other hand, being considered equal to material goods, ignoring their intrinsically abstract, immaterial nature. Both of these are incorrect ways of viewing such services, in that both ignore fundamental aspects of this field.

The provision of services implies the concept of action, a notion often difficult to define. Action is usually part of routines or programmes that select the actions successfully performed in the past by the actor. Using routines means acting in contexts where the meanings are shared and relatively stable; in this way, we can select the correct action with a minimum commitment of cognitive resources.

According to this theory, action is usually invisible; we act “without thinking” until something opens our eyes to it: it is the failure of action itself, which opens a gap between expectations (the outcome we thought the action would have) and experience (what in fact happened). When this happens, we become capable of reflecting on the action, which becomes the object of our attention. The position of Weick (Lanzara, 1993) on this point can be shared: the actors perform their actions in contexts considered to be realities constructed by the actors themselves, capable of giving meanings. The action is an answer to contexts constructed by man. Therefore, generative acting is possible only when familiar contexts are disrupted in favour of new contexts. This is an inter-active process, neither individual nor generically collective. It is therefore of primary importance to negotiate meanings: the action assumes a meaning only in an interpersonal context where every action is performed in response to or in connection with other actions. In conclusion, the supply of services is based on the production of immaterial goods obtained in cooperative, relational ways, in contrast to goods obtained according to a technical “material” logic.

* Department of Psychology, Università Cattolica del Sacro Cuore (Catholic University of the Sacred Heart) of Milan, Italy. Specializing in Clinical Psychology, at the Clinical Psychology and Psychotherapy Service, ‘San Raffaele’ Life-Health University, Milan, Italy.

From what has been said so far, there is clearly a great need for a definition – or re-definition – of the concept of competence in relation to the professional role of psychologists working in the services, where the relational aspect is paramount. According to the traditional definition, competence means a body of knowledge (practical and theoretical) that the subject uses in a wide range of situations to perform actions functionally linked to an objective (Lanzara, 1993). The competent actor uses the action programs, which usually contain general norms for action, in order to maintain the flexibility that we usually attribute to competent behavior. The ability to discriminate between different kinds of context is a fundamental element of competent action.

Alongside the traditional definition, there is another one that emphasises the importance of the gap existing between the abstraction and immateriality of the cognitive programs guiding competent behavior and the concreteness of competent action in natural circumstances. On this point, Lanzara (1993) talks about the “ecological” perspective: in this viewpoint, the context plays a central role since the competence obtained in a given medium (i.e. with certain tools and on certain objects) is rarely transferable to another medium. In fact, it requires the knowledge of the characteristics of the different contexts and the specification of new routines related to the different conditions in the different mediums. In the service field – where the interplay between actor and context is so important – this way of viewing competent behavior seems to be very useful and relevant.

Besides the problem of competence itself, there is another important aspect linked to it: the social legitimation of competent behavior. In this perspective, competence involves the mastery of strategies designed to give answers to problems emerging from the social context one belongs to. According to Carli, Paniccia & Lancia (1988) the references that legitimate competent acting in a professional function are:

- The technician/layman relationship: the layman (the beneficiary of the professional performance) is not competent and makes a demand addressed to the technical competence of the professional; the legitimation derives from the latter's capacity to respond to this social demand (Carli, 1989). The technician's response establishes his power, since this response represents the expression of his different degree of competence compared to the layman. It is a so-called “substitutive” modality of presenting oneself to the users: the professional's performance “fills” the vacuum (need-request) presented by the client (Circolo del Cedro, 1992; Carli, 1996b).

- Membership of the reference group: it is by belonging to a group that one's professional identity is established, legitimating one's action. Reference to the group prescribes the methodologies and techniques to be shown upon the client's demand.

These aspects are useful when the actor is in definite or relatively stable contexts, but may become obstacles when it is necessary to change consolidated programmes of action which are no longer useful. This often happens in providing psychological services, a domain where multiform and rapidly changing contexts force the operator to constantly adapt his perspective of action. If this characteristic is ignored, the services provided will have nothing to do with the user's demand and the services offered by the professional will be dangerously standardized.

Consequently, it is fundamental to define the psychologist's “working tools”: this entails opening up a space for reflection about what are the traditional modes of working and about our behavior in contexts where one is present in a professional capacity. This means defining what we are offering the client – apart from the technicisms – in relation to the social demand we are trying to satisfy. This abandoning of old familiar frames of execution and application so as to adopt new ones can easily seem dangerous, since this can challenge the most fragile parts of our professional identity. However, it is this operation that often proves necessary in the complex social contexts in which we live.

Di Ninni identifies three dimensions characterising a profession (Berdini & De Bernardis, 1991):

- The institutional aspect of the profession, that is, the set of tools, the methodology, the purposes, the professional identity, the way of treating the demand and of organizing the technician/layman dynamic;
- The aspect of differentiation of those belonging to a profession, considering the different organizational structures in which they operate. This involves the translation of one's own institutional aims and those of the facility into goals consistent with the users' demands;
- The aspect concerning the relationship between individuals and the facilities they feel they belong to; this is related to the possibility for the single subjects to reflect and to produce knowledge about the "sets of representations they use to depict their own role to themselves" (Berdini & De Berardinis, 1991, p. 62).

The last dimension is paramount in the case of the clinical psychologist. It can be said that the central aspect of his competent behavior is the capacity to continually re-define and re-think his actions in the professional relationship, in order to have an appropriate view of the domain in which he is working. Despite its importance, this dimension has been neglected in the practice of psychology for many reasons. First of all, the clinical psychologist is often called on to satisfy demands that are contradictory and unclear; he finds himself in the position to do something, no matter what it is. Moreover, the request to specify the characteristics of his way of operating – compared to other professional figures with whom he works – can create the need to constantly seek new aspects that can legitimate his own way of working (Kaneklin, 2003). Such a situation is related to the cultural assumptions permeating the Italian Psychological Services. On this point, the term culture refers to an implicit system that the members of a specific organization share in order to interpret reality. The culture defines and permeates the nature of the services provided (Lombardo & Mucelli, 1989). Despite the coming of the psychiatric reform (law n. 180), the "medical model" has for a long time been the core underlying the culture of the psychological services. The medical tradition shares a technical model based on certain assumptions (Fossi, 1991):

- The optimal functioning of an organ;
- An optimal mode of functioning of the organism, which leads to a state of well-being;
- A change in these conditions due to exogenous or endogenous factors;
- A set of procedures for the formulation of a diagnosis and a prognosis;
- A progress of the illness which hopefully ends with the recovery of the initial state of health.

In the praxis based on the medical model, the processes of knowledge-getting and intervention do not involve the clinician/patient relationship (Guerra, 1997); these processes need to take place within it, but it not considered the tool and object of the investigation: "the client talks about his problems using his own categories; to intervene on these problems, the psychologist must at the same time also intervene on the categories" (Carli & Paniccia, 2004, p. 77). This type of approach underlies the normal practice in the Italian Services, also among psychologists, probably because it seems to guarantee a stronger professional identity and a more reassuring model of action compared to the more modern "relational" approaches. The "medical model" therefore constitutes a catalyst that can increase the sense of belonging and of cohesion in a shared, credible paradigm (Lombardo & Mucelli, 1989). According to the "medical model", the operator and the patient behave as if they were following a kind of script. The professional is the saviour: his competent behavior is capable of defeating illness. Therefore a split takes place: on the one hand there is the operator

(symbolizing “good”) and on the other the illness (symbolizing “evil”), considered as a separate part of the patient (who tries to remove from himself the thing that makes him suffer). All this implies a relationship in which the aspects of regression and of delegation of responsibility are paramount (Simonelli, 1993).

As we have already seen, in Italian Mental Health Services, psychological practice is often influenced by the so-called “medical model”, which however proves methodologically inadequate for clinical psychology, since psychological symptoms are not simply the effect of a cause but need to be interpreted in their multiple meanings. This does not entail rejecting the “medical model”, which represents the origin of clinical psychology work. Instead, psychologists should view it critically so as to improve their competence, avoiding the use of a well-known, reassuring model like the medical one in the attempt to escape from a sort of identity crisis that has been afflicting clinical psychology in Italy for some time (Filippi, 1991). An interesting way of defining the competent behavior of the clinical psychologist makes reference to one of the central aspects of psychological work: the so-called user-oriented approach (Carli, 1996b). According to this approach, the proper intervention does not consist of mechanically applying techniques and procedures (for instance, psychotherapy procedures), but of a more careful consideration of the needs presented by the user in the context of the demand for intervention. This means identifying new ways of defining problems of psychological competence. In a service in which the doctor/patient relationship is managed according to the “medical model”, the role of the psychologist is that of establishing a (mental) space to allow the patient to think of the script in which he is involved in the context of his relationship with the doctor and the facility. In doing this, the psychologist becomes able to communicate with the patient’s subjectivity, an aspect usually neglected in daily medical practice (Carli & Paniccia, 1989; Ugazio, 1989).

We are back at the initial question: what are the main social requests that the psychologist has to respond to appropriately? Is the user of psychological services a *prosumer*, being at the same time producer and consumer of the service he is using (Normann, 1984)? In the psychological domain, the user is a *prosumer* in a particular way: usually the user’s competence to cooperatively “produce” the service is the initial requirement for engaging a professional. By “competence” we mean the client’s capacity to represent to himself (even partially) the characteristics of the service he is about to use; in this case, it is right to talk about a *prosumer*. In the domain of psychological services, on the other hand, this type of competence actually constitutes the goal to reach (Salvatore & Pamplomatas, 1993; Simonelli, 1993). However, the inadequacy of the advance representations of the psychology service enables the user’s demand to be interpreted symbolically. The professional functions we usually attribute to the psychologist (psychotherapy, counselling, educational interventions, training) are pre-texts (Carli, Paniccia & Lancia, 1988; Salvatore & Pamplomatas, 1993) in relation to what is really offered. Here we are dealing with cultural models for describing the psychology intervention that are anchorages through which psychological methodology can express itself and gain social visibility in the historical and cultural context where the psychologist works (Carli, Paniccia & Lancia, 1988; Carli & Paniccia, 1993; Salvatore & Pamplomatas, 1993).

To make proper use of the relationship, considered as a pretext, it is necessary to read the context properly: this means interpreting the situation so as to choose the behavior most appropriate to it. Moreover, the situation interpreted will be able to give meaning to our actions in that framework, making them intelligible. To set up a “made to measure” psychological intervention it is therefore essential to make a detailed analysis of the data: in this perspective, the careful observation of the context is a fundamental characteristic of the user-oriented approach.

The formulation of the social and individual phenomenological analysis model that we will examine has been studied by Carli and his collaborators for many years (one of his seminal articles from 1976 was “Trasformation and change, Archive of psychology, neurology and psychiatry”). In accordance with the so-called new approach to planning – the main aspects

of which have been described above – Carli & Paniccia (1981) underline the importance of two dimensions in the analysis of individual and social phenomena:

-Organization: this concerns the aspect of the rational, consensual achievement of the goals explicitly set by the actors. Organization guarantees the efficiency of the transformational process, through the subdivision of roles, the specification of each person's tasks, the modes of decision-making and communication, the strategies used; it is the dimension that is, as it were, visible to all.

-Institution: this concerns an “established, necessary, a-historical, fixed and eternal mode of relating (law, state, education, religion, parental network) which is found in, influences and regulates social groups and organizations, but that, unlike the latter dimensions, is not manifested structurally and therefore cannot be concretely found in society” (Carli, 1976, p. 177). The Institution is concealed and implicit in the Organization: it constitutes the emotional side of organizational action.

Institutional aspects – usually considered useless obstacles to the achievement of rational goals – are however an essential dimension. The institutional dynamic is the way the actors' unconscious interacts so as to share the affective symbolizations of events, contexts, and relationships. In this sense, it is possible to compare the institutional domain to the principle of symmetry, and the organizational domain to the principle of asymmetry (Matte Blanco, 1986). In other words, institutional operation refers to the way the unconscious works, considering the characteristics identified by Freud (1915) (Matte Blanco, 1975): lack of the principle of non-contradiction, absence of the categories of time and space, substitution of the external reality with the internal reality. Everything in the unconscious is symmetrical; it is a homogeneous, indivisible system where every relationship (John is Robert's father) can be considered at the same time its opposite (Robert is John's father). In psychoanalytical terms, one can talk about a primary process, in which the psychic energy floats freely among the representations, according to the processes of condensation and shifting, in contrast to the secondary process, in which the libidinal drives are more stable and definite (Laplanche & Pontalis, 1967). We can say that the Institution has to do with the way the primary process elaborates the stimuli coming from the social context; this is a different level of elaboration from the organizational level. This in fact refers to the conscious mode of functioning, according to the secondary process: in other words, asymmetric relations are extracted starting from the homogeneity of the (unconscious) symmetrical system (Carli, 1993). As we have already said, Organization is comparable to the asymmetric mode of mental functioning (Matte Blanco, 1975): the conscious system has the role of extracting parts from the amorphous mass of the unconscious – the symmetrical mode of being – so as to create a conceivable version (in terms of the categories typical of the asymmetric mode of being, that is, space, time and logical relations). This is an operation similar to “describing something immaterial by means of material images” (Matte Blanco, 1975, p. 123). The institutional domain allows the reciprocity inside transformational organizations to be managed, using pre-genital relational models (unconscious, not entirely mature), in which splitting and projective processes are often used (Carli & Paniccia, 1981, p. 140): this is our heritage of unconscious contents. The specific phantasmic aspects of the Institution are so important because they are the main components motivating the individual to act (Carli, Paniccia & Lancia, 1988). On this point, Freud talks about free energy, coming from the unconscious, as the driving force of psychic activity. In other words, the central idea is that every social relationship is read in the light of the affective categories making up the unconscious. On this, Franco Fornari proposes the concept of *Coinemi* (from the Greek *koinòs*, common) to refer to the affective categories common to every subject: the Author identifies the father, the mother, the brother, the sexual organs, sexual union, life and death. These categories form a living code that structures the mind of each person. This structure “operates both at the level of private symbolization and of public symbolization” (Maisetti Mazzei, 1987, p. 26). The characteristics of this code (universality, reference to primary relations and to the instinct of reproduction) puts it in a position to guide every individual in the process of attributing affective meanings to the elements of the context, whether it be personal or public. Close to

this conception, Eric Berne (1964) talks about the States of the Ego, defined as coherent systems of feelings and behaviors. These States of the Ego are “psychological realities” (p. 25) which refer to: 1. parent figures; 2. states serving for the objective assessment of reality; 3. states representing remote relics of childhood. Such states give form to every social relationship, by attributing a role (according to the predominant state) to each actor participating. Therefore the Institution – whose function can be compared to that of the code of the Coinemi or to the system of the States of the Ego – is a sort of “lens” through which each individual gets close to reality, interpreting it as if he were currently living in a peculiar primary relationship (among those that structure the unconscious). In traditional psychoanalytical terms, the idea of transference can be seen as an analogous concept; in fact, it is merely “a repetition of childhood prototypes that is experienced with a strong sense of actuality” (Laplanche & Pontalis, 1967, p. 644). As in the case of transference, the manifestations of the Institution are not literal repetitions of the primary models, but symbolic equivalents to what has been transferred.

If the actor is capable of thinking his fantasies (the content of the Institution), instead of acting them out, he will also be able to connect the actions to objectives that are consistent with the conscious system (the Organization): the rationally defined purpose is now achievable, since the Institution is at the service of the Organization. The fine balance between Organization and Institution can break down when the need for change arises. In these cases, internal and external (organizational) factors require changes that are not followed by adequate transformations at the Institutional level: the explicit objectives change, unlike the emotional and relational dimension which supports their achievement. In this way, there is a so-called reification of the institutional dynamic, which necessarily leads to irrationality and conflict. The Institution (implicit dimension) no longer serves to adequately support the changed organizational situation (explicit dimension). Therefore the core of the psychosocial intervention is the institutional domain, whose primary expression is collusion (from the Latin, *cum-ludere*, play with someone), defined as the social manifestation of an unconscious system. Collusion maintains cohesion and social harmony on the basis of a shared emotional symbolization of the context (Carli & Paniccia, 2004), avoiding the constant use of the asymmetric/conscious mode of being (Matte Blanco, 1986), which requires a great outlay of cognitive resources. Colluding means simplifying the reality on the basis of the “few things of which the unconscious speaks” (Carli, 1990, p. 290). Two or more actors colluding in a relationship play out a sort of rigid role-play (a script), in which the roles and the functions have the purpose of maintaining a certain system of reciprocity (Berne, 1964). The collusive mode of knowledge is based on the negation of the individual: the characteristics of the single subjects are in fact traced back to emotive categories and family scripts. Collusive processes include what is unknown in well-known frames, since unconscious categories arise and take the form of parental figures – a sort of language of the unconscious (Carli, Paniccia & Lancia, 1988). In other words, the reality is read through the distorting lens of the individual’s phantasmic family history (Berne, 1964; Freud, 1912; Maisetti Mazzei, 1987).

The concept of collusion is not only applied to transformational organizations (schools, businesses, services); we can use it to interpret every phenomenon of relating (individuals, groups, families). It is a crucial notion since the clinical psychologist has to deal with requests for intervention that represent, in the way they are “acted out”, the symbolic manifestation of the reasons that prompted the individual to ask for a psychological consultation (Carli, 1997). In these cases, the collusive dynamic, previously able to support the organizational aspects of the relationship of which the user is part, is no longer adequate – as we have already seen. This hiatus between Organization and Institution, caused by an inappropriately managed need for change, determines the reification of the collusive structure. The “game” (collusion) becomes fossilized and hinders the achievement of the explicit organizational objectives (Paniccia, 1989; Carli, 1996a), preventing a generative development of the relationship. Such a situation usually leads to the request for intervention. Faced with the user’s symptomatic (collusive) demand, the psychologist has to interpret the processes of attribution of phantasmic meanings towards himself and towards the facility where he works

(Malagoli Togliatti & Costanza, 1993), so as to understand why the patient is making a request for psychological consultation. Moreover, the clinician must also be able to interpret his own fantasies about the intervention and about the user, as well as the way the clinical operation could collude with the patient's phantasmic attributions. In traditional psychoanalytical terms, the situation in which the psychologist finds himself is permeated by the process of projective identification: the user projects part of himself (unconscious contents) onto the psychologist, so as to induce him to behave consistently with the projected parts. For example, the user might experience the therapeutic relationship like that of a father/son, pushing the psychologist to act as if he were the father. This is a symptomatic collusive request that needs to be interpreted, so that the intervention can be planned appropriately. On an operative level, it is useful to pay attention to the analysis of the user's expectations and to the analysis of the pattern of connection – that is, the way the client initially makes contact with the psychologist or with the facility where he works (Ugazio, 1989). Considering these aspects is important because it provides information about the collusive models the client will probably repropose in the clinical setting. Besides this, it is fundamental to explore the relationship existing between the figure commissioning the intervention (such as the parents, the head of a firm, a team trainer) and the end user (such as a son/daughter, a worker, a professional sportsperson) of the clinical work: in fact, the commissioner might collude with the operator in the attempt to make the intervention coincide with his own manipulative aims. The commissioner will often try to lead the user to a "correct" position, consistent with the collusive model he is trying to impose (Carli, 1987; Carli & Paniccia, 2004; Paniccia, 1989). Within this configuration, the psychologist helps the client to think of his usual (pathological) modes of relating, of which he is unaware (De Coro & Grasso, 1988). Interpretation is a fundamental tool to reveal the game (the collusive models) that the client is trying to re-establish in the therapeutic relationship (Carli & Paniccia, 1981). In this sense, the client's demand does not contain only a request, but also an implicit diagnosis and a proposed therapy ("we are having trouble in our relationship, we need marriage counselling") that the user wants to legitimate (Guerra & Paniccia, 1987). This is the ambivalent character of the demand, at the same time the desire to change and the request to treat a problem that is already identified. The analysis of the demand must disappoint the expectations and prefigurations of psychological work, so as to create a space for reflection on them. The psychologist has the task of rejecting the collusion offered by the client, to open a new way of considering the problems presented. All this produces so-called "category confusion" (Carli, Paniccia & Lancia, 1988), a state in which the individual is prompted to make a critical rethinking of the cognitive and affective categories used regularly in the collusive modality: what was before considered a mistake, can now be considered a resource, and vice versa. This is somewhat similar to the process of cognitive reorganization described by Gestalt theoreticians like Wolfgang Köhler and Max Wertheimer in relation to problem-solving processes. When reorganization takes place, the cognitive and affective components are arranged in a new, original way in which every component takes a different position from the others (Legrenzi, 1994). This new organization is qualitatively different from the first: it is made up of the same components (cognitions, emotions, affects, etc.), but within it they take on different reciprocal relations, thus favoring a new way of approaching problems. Category confusion is promoted by an insight that can lead the subject to consider the elements of the problem in a global way (Köhler, 1929). To carry out the analysis of the demand properly, three fundamental theoretical-methodological requisites must be considered (Malagoli Togliatti & Costanza, 1993):

- The analysis of the context: the operator and the user are considered part of a system. They have a certain vision of the world and are influenced by the socio-cultural context in which they live.
- The rejection of a preconstituted therapeutic relationship: the passive acceptance of a psychologist/user relationship on the lines of the "medical model" can easily lead to collusion,

preventing the relationship from being interpreted in a dynamic, creative way. This could constitute an obstacle to the constructing of a “made to measure” therapeutic intervention.

- Epistemological change: the operator’s role does not consist of leading the client towards a predefined objective (“orthopaedic modality”), but of promoting a process of analysis and reflection. The client is considered an active responsible individual in the process of constructing his own vision of reality.

Therefore, the model of analysis of the demand sets itself the aim of producing generative knowledge, rejecting an orthopaedic modality of change (which holds that the relationship can be “re-aligned” to a certain correct initial position) (Scotto di Tella, 1992). The psychologist therefore guarantees the activity of reflection: in this way, he is able to place the client in the position to assume a new, responsible attitude towards his life, particularly concerning the problems that he is experiencing and that he brings to the clinical setting. We have so far summed up a proposed unified clinical approach, as it was expounded in the pages of the *Rivista di Psicologia Clinica* (later *Psicologia Clinica*) during the 1980s and ‘90s. It would be wise to underline that this is not (or should not be) another clinical theory, but an attempt to create a metalanguage which, as unified methodology, can identify each time the criteria that make the various points of view cogent (Salvatore, 2006). I believe the idea of a unified clinical psychology is very important, specifically for two reasons:

-There was (and in part there still is) a great fragmentation in clinical psychology, and in psychology in general, due to the existence of the great number of theoretical models and professional practices, not infrequently in conflict with each other (Sternberg & Grigorenko, 2003). This heterogeneity makes it difficult for the client to form an organic picture of the role of psychology that can serve to catalyse the demand from society: in other words, the (potential) client has no precise knowledge, even partial, of what a psychologist actually does.

-Psychology as a discipline tends to reify its objects of study: in other words, a concept (such as the unconscious) can be decontextualized from the theoretical model it belongs to, to assume different meanings and to refer to states of reality (Kimble, 1994), rather than to a construct, which is simply the abstract concept used to indicate psychic life globally (Pedon, 1995). Consequently, psychology tends to choose its objects of study directly from reality: “the discipline is anchored not to psychological objects (that is, to models based on a theoretical construct), but to phenomena of reality, as they appear on the historical plane, at a pre-scientific level” (Salvatore, 2006). For instance, “scholastic psychology cannot be interpreted as a specific, autonomous area of psychology, since school is not a systematic domain endowed with psychological specificity. What happens in school is obviously of interest to psychology; however, the phenomena that the psychologist observes in school do not acquire psychological meaning simply because they take place in that context” (Salvatore, 2006). The fragmentation of the discipline and the overlapping of the historical and scientific plane in considering problems of disciplinary interest can cause confusion not only in the client, but also in those who are intending to make psychology their profession. The two aspects mentioned make it difficult to answer some specific questions that a student asks himself when his psychology degree is not far off: what does a psychologist actually do? What can a psychologist do? What are his “working tools”? What problems do we have to deal with as psychologists? How can we provide answers to such problems? What – if any – is the “psychological modality” of dealing with problems, apart from the great number of schools and methods? As a young psychologist, for me it is difficult to answer these questions, considering the heterogeneity of the theoretical and practical models. One can therefore support the position of Sternberg & Grigorenko (2003) about the usefulness of a general methodological approach that can give value to any specific theory that can throw light on the problem considered. This would not be a generic a-theoretical approach – since every intellectual proposal necessarily entails assuming a specific perspective –, but an approach based on concepts of great heuristic and practical value, deriving from the main psychological theories. I believe that clinical psychology needs a unified perspective from

which it is possible to study the object of investigation without ignoring the existence of the inevitable practical/theoretical differences (Sternberg & Grigorenko, 2003). It is therefore paramount to set up a general theoretical framework that can integrate the characteristics of greatest efficacy of theories that are alternatives to each other (Kalmar & Sternberg, 1988; Sternberg, Grigorenko & Kalmar, 2001). On this point, the Authors talk about a higher order theory, which “involves the introduction of new elements that join theories together and that account for aspects of the phenomenon that were not considered by any previous theories” (Sternberg, Grigorenko & Kalmar, 2001, p.109). On the methodological plane, it is highly probable that single operations are inadequate for the global study of any psychological phenomenon; it is therefore useful to make use of so-called convergent operations (Sternberg & Grigorenko, 2003, p. 27), that is, to use multiple methodologies (such as questionnaires, observation, clinical interviews, different kinds of test, etc.) in order to study a single psychological phenomenon (for instance, prejudice). Each methodology used should integrate data coming from the others, providing a more detailed vision of the object. The danger that psychologists may easily fall into is that of behaving like the blind man in the story of the elephant: each one touches a different part of the metaphorical elephant, convinced that the part touched is the entire animal. Every object of psychological interest (such as memory, the emotions, consciousness, mental disorders), instead, should be considered from many different perspectives, each of which reveals a small but important part (for instance, neuropsychological, cognitive, educational, social aspects etc.) of the whole. On the theoretical plane, a system is needed to integrate the theories: Sternberg, Grigorenko & Karmal (2001) suggest that we can typically find that theories A and B are correct in some respects and incorrect in others. The aim is that of integrating “those aspects of the two [or more] theories that are empirically sustainable and discarding those aspects of the two [or more] theories that are not” (Sternberg, Grigorenko & Karmal, 2001, p. 109). When dealing with the issue of clinical psychology, it is fundamental not only to consider the empirical requisites of the competing theories, but also their heuristic value, that is their capacity to generate new models of knowledge and intervention.

In conclusion, we can consider two different levels of analysis in a unified clinical approach:

1. particular (practical): this is the methodological dimension, that is, concerning the way the psychologist uses his techniques. The main question is: how to integrate different methodologies without losing practical efficacy?;
2. universal (theory): this is the theoretical dimension, the “map” used by the psychologist to interpret the reality. The main question is: how can the different theories join together? On what level can this integration be carried out?

A unified clinical approach must be able to provide a shared theoretical horizon that envisages a methodological pluralism capable of contributing to the expansion of knowledge and to the use of multiple technical tools. The analysis of the demand proposal tries to provide a shared theoretical framework by openly borrowing from psychodynamic theory. In an interesting article, Drew Westen (1998) lists five general postulates on which contemporary psychodynamically-oriented clinicians should base themselves in everyday work:

1. most mental life is unconscious;
2. mental processes operate in parallel, so individuals may have contrasting feelings that motivate them to behave in opposite directions;
3. stable personality models are formed during childhood;
4. representations of the self, of others and of relationships guide people’s interactions and influence the way they become psychologically symptomatic;
5. the development of the personality involves a shift from a state of dependence and immaturity to one of maturity and interdependence.

It is not hard to see that every characteristic of the analysis of the demand model can be easily linked to these assumptions: the central position of the idea of Institution (postulate 1), the dualism of Organization and Institution (postulate 2), the way pre-genital models of an institutional nature influence human relations (postulate 3), the centrality of the concept of

collusion (postulate 4), the importance of coordinating the institutional domain with organizational aspects so as to achieve explicit objectives (postulate 5). Despite the explicit reference to a psychodynamic orientation, the analysis of the demand model includes concepts traditionally neglected by this theoretical perspective. The interpersonal dimension plays a central role in it, in accordance with the systemic approach and the contemporary psychoanalytical mainstream; moreover, the concept of Organization represents the dimensions of rationality, consciousness, "cold cognition", concepts traditionally ignored by a classic psychoanalytical approach. In fact, all these aspects are well-known and accepted in the clinical community, as they are considered of great heuristic value and empirically valid. They are ideas that have been progressively integrated into the psychodynamically oriented clinical approach because they are considered fundamental aspects of clinical interaction, as well as of human life. Along with the other notions so far considered, they constitute "a set of general principles that can be found in psychology today. These principles are applied everywhere within the discipline [...]" (Kimble, 1994, p. 510). In the original text, Kimble is referring to general psychology, but we can easily apply his quote to clinical psychology as well. Consequently, the analysis of the demand model can be considered an initial proposal for a unified clinical approach, based on a psychodynamically-oriented psychology. The theoretical horizon instituted (universal-general dimension) enables reality to be interpreted using a set of concepts like the unconscious, collusion, the relationship, the Institution/Organization dialectic. In such a frame, use can be made of any psychological technique consistent with the theory's modality of interpreting the clinical reality (practical-local dimension).

In conclusion, the main challenge to face in order to organize a unified clinical approach concerns the way practice is connected to theory and at the same time how techniques of different orientations can be used appropriately in the same (meta)theoretical framework. These are questions that require penetrating, in-depth reflection: a healthy dialogue between theoreticians and clinicians is the only hard road to travel in order to achieve a unified and unifying approach to clinical psychology.

References

- Bardini, G., & De Berardinis, D. (1991). Riflessioni sulla formazione professionale dello psicologo clinico. *Rivista di Psicologia clinica*, 1, 60-67.
- Berne, E. (1964). *Games people play*. New York: Ballantine Books.
- Carli, R. (1976). Trasformazione e cambiamento. *Archivio di psicologia, neurologia e psichiatria*, 1(2), 148-194.
- Carli, R. (1987). L'analisi della domanda. *Rivista di Psicologia clinica*, 1, 38-53.
- Carli, R. (1989). La fase istituyente della professionalità psicologica. *Psicologia Italiana*, 10(2), 25-29.
- Carli, R. (1990). Il processo di collusione nelle rappresentazioni sociali. *Rivista di Psicologia clinica*, 3, 282-296.
- Carli, R. (1993). L'analisi della domanda collusiva. In R. Carli (Ed.), *L'analisi della domanda in psicologia clinica* (pp. 5-39). Milano: Giuffrè.
- Carli, R. (1996a). Psicoanalisi: mandato sociale e formazione. *Psicologia clinica*, 1, 5-22.
- Carli, R. (1996b). Psicologi e Servizio Sanitario Nazionale. *Psicologia clinica*, 1, 30-41.
- Carli R. (1997). Editoriale. *Psicologia clinica*, 3, 5-25.

- Carli, R. & Paniccia, R.M. (1981). *Psicosociologia delle organizzazioni e delle istituzioni*. Bologna: Il Mulino.
- Carli, R., & Paniccia, R.M. (1989). Psicosociologia dell'ospedale: riflessioni sul ruolo dello psicologo clinico. *Rivista di Psicologia clinica*, 2, 148-160.
- Carli, R., & Paniccia, R.M. (1993). Percorsi per la definizione del prodotto in psicologia clinica. *Rivista di Psicologia clinica*, 2-3, 21-45.
- Carli, R. & Paniccia, R. M. (2004). *Analisi della domanda*. Bologna: Il Mulino.
- Carli, R., Paniccia, R. M., & Lancia, F. (1988). *Il gruppo in psicologia clinica*. Roma: Carocci.
- Circolo del Cedro. (1992). La competenza psicologico-clinica. Riflessioni e proposte del Circolo del Cedro. *Rivista di psicologia clinica*, 1, 6-37.
- De Coro, A. & Grasso M. (1988). La consultazione psicologica in un centro di psicologia clinica: note sull'osservazione del transfert nella fase di valutazione. *Rivista di Psicologia clinica*, 2, 149-160.
- Filippi, L. S. (1991). Sull'esigenza prioritaria di una "diagnosi integrata": contributo all'epistemologia del rapporto tra psicologia clinica e psichiatria. *Rivista di Psicologia clinica*, 3, 266-273.
- Fossi, G. (1991). Quale modello per la psicologia clinica?. *Rivista di Psicologia clinica*, 3, 274-278.
- Freud, S. (1912). Tecnica della Psicoanalisi. In Freud, S., *Opere*: vol. VI, Torino: Bollati Boringhieri.
- Freud, S. (1915). Metapsicologia. In Freud, S., *Opere*: vol. VII, Torino: Bollati Boringhieri.
- Guerra, G. (1997). Psicologia Clinica e Psicologia Generale. *Psicologia clinica*, 3, 58 -66.
- Guerra, G. & Paniccia, R. M. (1987). Analizzare la domanda: un caso di intervento in un Servizio di Diagnosi e Cura. *Rivista di Psicologia clinica*, 1, 54-64.
- Kalmar, D.A. & Sternberg, R.J. (1988). Theory knitting: an integrative approach to theory development. *Philosophical Psychology*, 2, 153-170.
- Kaneklin, C. (2003). *Produzione di valore per l'utente e integrazione professionale-organizzativa*. Paper presentato al Congresso Nazionale ASL 18 La qualità dell'assistenza per una migliore qualità della vita, Alba, Italia.
- Kimble, G. A. (1994). A frame of reference for psychology. *American Psychologist*, 6, 510-519.
- Köhler, W. (1929). *Gestalt psychology*. New York: Liveright.
- Lanzara, G.F. (1993). *Capacità negativa. Competenza progettuale e modelli di intervento nelle organizzazioni*. Bologna: Il Mulino.
- Laplanche, J. & Pontalis, J.B. (1967). *Vocabulaire de la psychanalyse*. Paris: Presses Universitaires de France.
- Legrenzi, P. (Ed.) (1994). *Manuale di Psicologia Generale*. Bologna: Il Mulino.
- Lombardo, G.P. & Mucelli R. (1989). Modelli del mentale e cultura organizzativa: la pratica clinica nei Servizi di Salute Mentale. *Rivista di Psicologia clinica*, 1, 15-26.
- Maisetti Mazzei, F. (Ed.) (1987). *Psicoanalisi, arte, persona*. Milano: Franco Angeli.
- Malagoli Togliatti, M. & Costanza, G. (1993). La costruzione del cambiamento nell'analisi della domanda. In R. Carli (Ed.), *L'analisi della domanda in psicologia clinica* (pp. 41-57). Milano: Giuffrè.

Matte Blanco, I. (1975). *The unconscious as Infinite Sets: An Essays in Bi-Logic*. London: Gerald Duckworth & Company.

Matte Blanco, I. (1986). Sigmund Freud: capostipite di una nuova epistemologia. *Rivista di psicoanalisi*, 3, 331-341.

Normann, R. (1984). *Service Management. Strategy and Leadership in Service Bussiness*. John Wiley & Sons.

Olivetti Manoukian, F. (1998). *Produrre servizi. Lavorare con oggetti immateriali*. Bologna: Il Mulino.

Paniccia, R.M. (1989). La collusione. *Rivista di Psicologia clinica*, 3, 291-306.

Pedon, A. (1995). *Metodologia per le Scienze del Comportamento*. Bologna: Il Mulino.

Salvatore, S. & Pamplomatas, A. (1993). Il prodotto in psicologia clinica. Considerazioni sulla capacità di domanda del mercato. *Rivista di Psicologia clinica*, 2-3, 92-122.

Salvatore, S. (2006). Models of knowledge and psychological action. *Rivista di Psicologia Clinica*, 2-3, da www.rivistadipsicologiaclinica.it.

Scotto Di Tella, S. (1992). Analisi della domanda e restituzione della delega come elementi caratterizzanti la professionalità psicologico-clinica. *Rivista di Psicologia clinica*, 3, 301-311.

Simonelli, C. (1993). Alcune riflessioni sulle caratteristiche dell'invio allo psicologo clinico da parte del medico. In R. Carli (Ed.), *L'analisi della domanda in psicologia clinica* (pp. 231- 238). Milano: Giuffrè.

Sternberg, R.J. & Grigorenko, E.L. (2003). Unified Psychology. In Kazdin A. E. (Ed.), *Methodological Issues and Strategies in Clinical Research* (3rd ed.) (pp. 23-47), Washington, DC: American Psychological Association.

Sternberg, R.J., Grigorenko, E.L. & Kalmar, D.A. (2001). The role of theory in unified psychology. *Journal of Theoretical and Philosophical Psychology*, 2, 99-117.

Ugazio, V. (1989). L'indicazione terapeutica: una prospettiva sistemico-costruttivista. *Terapia familiare*, 31, 27-40.

Westen, D. (1998). The scientific legacy of Sigmund Freud: toward a psychodynamically informed psychological science. *Psychological Bulletin*, 3, 333-371.