Clinical Psychology trainers and professional helpers

by Antonio Imbasciati*

In the environment of university professors and researchers in Clinical Psychology in Italian universities there has emerged a two-fold and at times opposing cultural-methodological orientation: on the one hand, the focus is on the interpersonal relationship with its interactions and the psychologist's relational skills as the fulcrum of clinical work, in a science viewed as empirical and person-centred; on the other, the emphasis is on psychobiological and psychophysical research, mainly in the laboratory, and the contribution of the neurosciences as the fulcra of what is considered a more direct and precise clinical intervention carried out using the more general methodology of the biological-medical sciences. There is a difference in what is meant by "clinical" in the two approaches (Imbasciati, 2007b); the differences, not explained clearly enough, have given rise to misunderstandings and to standpoints that are damaging to the identity and image of Clinical Psychology itself, with not insignificant effects on the work of all professional psychologists.
This double, divergent tendency is found in the whole university corpus of sector M PSI 08 (Clinical Psychology). It has therefore become necessary to make a scientifically conducted effort to clear up the misunderstandings underlying the said divergences, their historical origin and the suitability of the different methodological approaches to the sciences currently providing models for assistance, as well as the organization of the broader field of Health optimization. I have been working on this for several years (Imbasciati, 2006a, b, c, 2007a, b, 2008; Imbasciati, Dabrassi & Cena, 2007; Imbasciati & Margiotta, 2008), but to carry on it is indispensable for there to be debate and contributions from different points of view.
Here I wish to underline that the divergences and the ambiguities causing them can undermine the professional future of all Italian psychologists.
In fact, the university teachers in whose field there are marked differences in approach are the trainers of the future professional psychologists: since most professional psychologists become clinicians, the teachers of sector M PSI 08 are those who will shape the future professional psychologists. Their training, their professional sense and their very idea of what is called "clinical" work will therefore reflect the loyalties of their trainers rather than the other tendency. The differences and divergences that are found in the academic environment are therefore anything but irrelevant as concerns the future of the whole psychology profession, and the form it will take, how it will expand or shrink in Italian society. This future should be of interest to the professional Order and the other Associations that defend the profession.
Apart from the diatribe which is still underway about which approach is more scientific (for example, the *Impact Factor* debate) and which is less useful, I would here like to suggest some consequences on the future of the profession of psychologists - the great majority of whom are in what is called the clinical profession - depending on whether they receive a training based on one approach rather than the other, that is, depending on the prevailing type of trainers they will have had.
The medicalization of the services (Imbasciati, 2008b) and the hierarchical dominance of psychiatrists over psychologists[1] will most likely favour the second of the two positions mentioned above: this could produce a conception of Clinical Psychology as being centred exclusively on deficit correction (Carli, 2006) and not on personal growth, i.e. pathology-centred. This is also usually implied both in the medical-assistance domain and among the clients, in the form of a

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[1] Psychiatrists often claim that as the psychiatrist is a Specialist while the psychologist is only a graduate, the above hierarchy can be justified: but no psychiatrist would ever dream of considering an engineer, a economist or a jurist, whose advice he needed, in the same way as he views the psychologist. The implicit assumption is that the psychiatrist considers himself a Specialist also in Clinical Psychology.

normal/pathological attitude that is all very well in medicine, but which is inappropriate and misleading for the psychic domain (Imbasciati & Margiotta, 2008); other concepts transferred from medicine to psychology are equally inappropriate and misleading (Turchi & Perno, 2002). Also the concept of the intervention - that is, of the professionality of the psychologist - that is favoured will be misleading in terms of the psychic field, which should be what psychologists deal with (Carli, 1987, 1996, 2006; Grasso et al., 2003, 2004). A further consequence, which in future may be conclusive, will be that psychologists in the health service will be asked to perform transitivist services: elsewhere (Imbasciati, 1993, 2008; Imbasciati & Margiotta, 2008) I have isolated and described a general paradigm underlying medical practice, which I called transitivism.
I am talking about the general, implicit conception which takes for granted that the health operator is the active agent who does something (or gets it done) to the patient, who, as the passive object of this transitive action affecting him, need do nothing but "be patient", and suitably compliant. The term transitivism derives from grammar: what the health worker does is like a transitive verb, a transitive action. This paradigm is appropriate to surgery and with a few restrictions also to medicine, but it does not suit the psychic at all. To be able to change the subject's inner structure, the clinical psychology intervention must work through a relationship, in other words, through a reciprocal action of mental processing of the intersubjective meeting: as the subject, who relates to the psychologist by their listening to each other, and is not forced into a relationship (many operators view the relationship as being based only on words and therefore on persuasion and essentially on manipulation), is more active than the psychologist himself, he can *actively* take something which, precisely because he himself actively elaborated it, will really make him change. This is an interpersonal model, which is identificational rather than manipulative (Imbasciati & Ghilardi, 1993).
The transitivist paradigm of the intervention unfortunately colludes with the present-day general culture of "everything, immediately, soon (and without suffering)" that is dominant today. Medical, surgical and biological technology favours this mentality: rightly, as long as the claim relates to the biological, but wrongly, with disastrous effects, when it is applied to the psychic. The psychologist should therefore be capable of analysing the demand of the users and of modifying their attitude and expectations. All this is far from easy if the Institution that permeates the health services is playing on the side of the users' expectations.
What will happen then for those psychologists who will have trained under teachers of a mainly psychobiological orientation? Due to their training they will find themselves unprepared to resist the joint requests of the Institution and the users, much less to change them. They will therefore try to apply medicalistic parameters and, as these are unsuitable for obtaining results of a psychic kind, they will fail, in the eyes of the doctors who unconsciously imposed such parameters on them through the Institution. The final outcome may be the loss of prestige for the psychologist's role in the health services, as well as a further disqualification of his image.
Similar damaging transformations may also come about at the level of private practice. In the current social climate, the users have assimilated medical-style intervention models (Grasso & coll., 2003) and with the support of the mass media, live in the optimistic belief that Science can offer easy, fast, effective remedies to every malaise that people absolutely do not want to suffer. How will the professional psychologist, untrained in the principles that shape the person-centred clinical intervention, be able to analyse the demand of the users (Carli & Paniccia, 1981; Carli & Paniccia, 2003), not to mention make them develop a different view of the psychic intervention so that they will move towards the intersubjective collaboration indispensable for such intervention? How will he be able to shift the users from the expectation of being passive objects of the operator's active, transitive intervention (which is the medical model: Imbasciati, 2008; Imbasciati, Cristini & Buizza, 2008), towards the idea that to change their state they will need to "work"? The passage from the psychological consultancy intervention to psychotherapy is part of a *continuum*: so what is the future for the psychotherapies?
But there is one last perspective, to be considered even more carefully for the professional future of psychologists, both in the public and private sectors. In the health field, while on the one hand a medicalistic model is offered and imposed for intervention in psychic "pathologies", on the other it does not seem to have been entirely forgotten that so-called normal people need psychological

help: but this help, and this demand, are completely misinterpreted. In fact, the official descriptions of many of the twenty-two degree courses in the health area (three-year now becoming five-year courses), envisage psychological-type functions - but without the essential basic training – which qualify the graduates as "professional helpers", in charge of (inevitably psychological) consulting for all the people who during any specific "health" care, need help with "personal problems". As psychologists we know how often, behind the reductive term "problems", there are personality dysfunctions, at times serious, which would need a specifically psychological intervention: the clinical psychology competences in the health area (and in the official descriptions of the health degrees) are called "human competences". As psychologists we know that this reductive definition of "human competences" harbours the psychological pipe-dreams of many operators (to do psychotherapy!?) camouflaged in oversimplification; and at the same time we know that beneath the appearance of a common, incidental consultation, the users camouflage and conceal a request regarding complex and often serious problems.

With the reductivist mentality that reigns in the medical field concerning the psychological sciences and dominates the medical conception of Clinical Psychology, the new course reorganization will de-qualify the psychology profession, handing its responsibilities over to other operators.

Of the twenty-two new degrees, no fewer than six clearly state in the official description of their future profession, responsibilities that years ago would have been attributed to psychologists. These new graduates are Educators, Psychiatric Rehabilitators, Speech Therapists, Physiotherapists, Midwives and Paediatric Nurses; but we can also add General Nurses, Orthopticians, along with other new professions that at present are outside the health field: Social Workers, Counsellors, Clinical Pedagogists and yet others that are being developed. All these professions will be the psychologist's future competitors: the race favourites.

In fact, while the official descriptions attribute to them responsibilities of a psychological sort which at first sight might seem different from those of the psychologist, the fact that these figures receive a very incomplete training from temporary or stop-gap teachers (Imbasciati, 2008, Imbasciati, Margiotta, 2008), facilitates confusion and presumption, so everyone will feel somehow "psychologists". The step from "somehow'" to actually being the thing, will be short. This is especially so if what is done is in itself easily distorted; and above all suited, i.e. colluding, with the users' expectations as well as with the medicalistic mentality which sees the psychologist's work as little more than common-sense psychology sharpened by experience (Imbasciati, 2007a, b, 2008).

To deal with these competitors who are the favourites of the system, what is needed is clinical psychologists well-versed in their *specific* conception of clinical work. This preparation should be based on the first of the two conceptions mentioned at the beginning, and that is, on a Clinical Psychology centred on the interpersonal relationship. Otherwise, these psychologists will have no advantage over these other "helpers". If instead they have been trained by teachers who favour the biological approach, they will certainly find themselves better prepared in biological-medical competences, but totally incapable of dealing with specific interpersonal tasks: this body of psychologists will either be lucky enough (the minority) to enter laboratories where they will certainly makes advances in Science, or they will go and naively obey incorrect medical-psychiatric dictates. These will be the majority, a workforce subjected to another culture.

It seems that so far both the professional Orders and the other Associations that defend the profession have considered the academic world and everything that happens in it as if it were totally detached from their professional competences. But this is not so: in ten or fifteen years' time the psychology "trade" will depend on what has happened in the academic world, i.e. in the background of the trainers, whose orientation will therefore completely determine the psychologist's work: it will depend on what happened in the changeover of teachers of Clinical Psychology, or on what kind of university teachers will be promoted to become psychology trainers.

Today there is a gap between the psychology profession and the academic world: can it be put right? Could this gap compromise the professional future of all psychologists, well beyond what is rather sneeringly regarded by some as "academic games"? The indifference may be due to a lack of foresight on the part of the professional Orders; or it may be due to misinformation.

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