EDITORIAL

by Renzo Carli[*]

Economic Technicalism

On the 24th January 2008 the Italian government led by Prime Minister Prodi fell after losing a vote of confidence, called in the Senate.
During its 20 months governing the country, the Prodi government had collected a lot of opponents. This happened despite the encouraging economic results, which were praised by the European Commission. Perhaps the antipathy was due precisely to the strictly "economic" approach adopted in governing.
It seems that this governing "like economists" which characterized the Prodi government, implied an underestimation and often a complete disregard for the emotional symbolism that the citizens associate with acts of government and with the way they are communicated. For instance: in a poster put up all over Italy during the first weeks in power, one of the parties belonging to the government coalition stated "Even the rich have to cry". Perhaps it would have been better to say that with the new government even the poor would be able to smile. That message seemed to be pointlessly and indiscriminately threatening. Who are the rich that have to cry? Many people, though on the left, wondered if that message was not also aimed at them, seeing that the standard of living in Italy has grown considerably since the second war. The expression "the rich" is old, obsolete, and symbolically ambiguous. The solution of the ambiguity is not clear and the message conveys suspicion and fear. It was a true masochistic act for whoever decided to spread that message. An even worse effect, a few months later, was created by the Minister for Economy and Finance Padoa Schioppa when he called young people living at home with their parents to a considerable age "bamboccioni"[1]. Here is an economist lacking in symbolic culture, but also lacking in political culture, full stop. The expression could apply to 10% or perhaps 15% of the "young" who live with their parents until they are over 30 years old out of personal choice. The Minister seems to be guilty of not knowing the situation of "youth precariousness"[2]: a situation where staying in the parents' house is not a choice, for those who are forced into an economic and working situation with no hope of advancement, with no valorization of one's competences, in repetitive jobs, as a replacement for somebody else, with no security for the future. It was a silly mistake by the Minister, therefore, which however indicates a far more serious and profound phenomenon: the idea that the economic management of a country can be justified "purely" in economic terms; with the hope that everyone will "understand" the meaning of the sacrifice they are asked to make, based on objectives such as having "the books in order", in a purely economic assessment of events and acts of government. What is lacking is any thought for the emotional motivation addressed to those who are "subjected" to economic policy. The economist who governs *self-referentially* carries out an "economic" government action, and hopes that the governed will share, who knows why, his own emotional dynamic associated with "putting the books in order": without explaining, motivating, setting goals that appeal to emotional dynamics that differ from his own, centred on the economy. If, within this self-referential behaviour, mistakes are made in emotional assessment like the one made by Padoa Schioppa, it is no surprise that the government's image starts to arouse rejection and dislike; this rejection comes not only from the

[*] Full professor of Clinical Psychology at the Faculty of Psychology 1, 'La Sapienza' University of Rome, head of the degree course in "Clinical Intervention for the individual, the group and the institutions", member of the Italian Psychoanalytical Society and of the International Psychoanalytical Association.

[1] In the literal sense of the word, the "bamboccioni" are the puppets, the rag dolls. The term is derogatory and evokes grown or big babies referring to the over 30 years old adults that still live at home with mum and dad .

[2] Temporary employment is wrongly called a youth phenomenon. For many years now it has been common all over the country to offer contracts for short-term work which create "flexibility" (the economic definition of the phenomenon, used in business), or "precariousness" (in the experience of whoever finds work only with this kind of contract). This precariousness concerns people who were young at the beginning of their working experience but who are now, still in the same precarious conditions, well and truly "middle-aged".

opposition but also from those who voted for the Left and made this government possible. It is a rejection that reflects the emotional symbolic vacuum of a political situation where everyone has trouble finding ideals, hopes, projects one can identify with, and values to pursue and defend.

An analogous situation, of emptiness and misunderstanding of the symbolic sense of what one experiences and does in one's work and in the theorization of one's work, is being created in clinical psychology.

Mala tempora currunt.

More and more commonly, opinion groups refer to the "objective" diagnosis and identification of personality disorders as the central procedure, which should precede and accompany every activity in psychotherapy. This is the alternative to making a report, considered lacking in precision and "scientific" validity, indulging in nineteenth century storytelling.
There is a tendency to confuse the symptoms with the problems that people and organizations bring to the clinical psychologist. The *symptoms*, which characterize the patient, are diagnosed with criteria related essentially to the DSM IV. The *problems*, however, are communicated by the person or the organization in a relationship with the clinical psychologist or the psychotherapist. Confusing symptoms and problems, confusing the diagnosis on the one hand, with the actual experience in a relationship on the other, is a serious matter; it is at the same time a practice defended more and more vociferously by those who expect to reduce the practice of clinical psychology to diagnosis-therapy[3], typical of the classical medical approach. One hears and reads more and more often statements like: if a *patient* presents a major depressive *disorder, an* obsessive-compulsive *disorder* and hypochondria, the clinician can give priority to the pharmacological treatment of depression. If, after the pharmacological treatment, the obsessive-compulsive *disorder* and the hypochondria persist, one should diagnose which *problem* began first. It is down to the clinical psychologist to decide to treat one disorder before another, keeping in mind and interpreting the opinion of urgency given by the patient in wanting to deal with a certain *problem*; finally the clinician must be able to direct the patient towards the most suitable therapeutic approach[4]. These authors, who elsewhere argue the need to found a *Psychological Clinic* in the place of Clinical Psychology, seem to orient their "clinical" gaze towards the patient, his disorders, and his symptomatology, in a *vision* that tends to confuse psychiatry with clinical psychology, planning to take the road of the evidence-based diagnosis, of empirical objectivity, with the aim of achieving a hoped-for comparability of "data".
Similar roads are taken by other colleagues, in the context of issues concerning assessment in psychotherapy.
These attempts are clearly legitimate and interesting. It seems, though, that they do not take into account how much is lost by going in these directions. This in my opinion is a loss of considerable importance. In the approaches just mentioned, one completely loses the sense of the relationship; hence one loses any possible interpretation of the relationship in terms of emotional symbolism. All this seems to be replaced by another symbolic dimension, acted out however, and not thought out: the symbolization of the person who claims to define the patient's "illness", to identify the appropriate treatment for that disorder-illness, to assess the efficacy of the intervention and to demonstrate its validity to the scientific community. Recently, with some colleagues interested in assessment in, I posed a question which at that time remained unanswered: *What are the factors that have made psychotherapy an activity sought after and followed by a great many people in most of the world, despite the lack of valid research that can definitively prove the efficacy of psychotherapy, in its results and its process?*

[3] Obviously the prognosis is missing. But how can a prognosis be formed without an aetiological diagnosis? How can a prognosis be pronounced based only on the identification of the symptomatological picture?
[4] Synthesis taken from: Rafanelli, C. & Fava, G.A. (2006). La valutazione dei fenomeni clinici tra qualità, quantità e giudizio clinimetrico [The assessment of clinical phenomena between quality, quantity and clinimetric judgement]. *Rivista di Psichiatria*, 41, 137-149.

I think Clinical Psychology can assume two very different attitudes to this question. On the one hand there are those who are trying to operationalize clinical psychology procedure so as to make it a diagnostic and therapeutic action with its standards and its protocols, with the aim of returning to the mainstream of western medicine, organized within deductive and inductive epistemology. This means that abductive logic is completely ignored: the paradigm of clues founded and supported, as Carlo Ginsburg reminds us, by *physicians* like Arthur Conan Doyle (the creator of Sherlock Holmes), Giovanni Morelli (founder of attributionism in painting) and Sigmund Freud. On the other hand, there are those who wonder what "force" lies in the Clinical Psychology intervention and in psychotherapy, what evaluation of it has enabled it to develop even without the contribution of the empirical approach. Perhaps those who practise psychotherapy organize its testing[5] as part of the procedure itself, in the relationship and the symbolic process characterizing it. If that is the area where the testing should be sought, then the objectivization of the disorder, the insistence on substituting the "objective" disorder for the problem as an eminently relational phenomenon, are aspects that may lead away from the more worthwhile road.
In this context it seems interesting to look at the difference between the "report" and "assessment scales or tests" in the understanding of Clinical Psychology.
But also, and it is the same thing, it is important to consider the difference between "diagnosis" and "relationship", in psychotherapy and in the clinical psychology intervention.

The diagnosis

The act of diagnosing is positioned in the area of evaluation of the "other" and of his disorders, or his pathology. It therefore entails a specific relationship: that in which a person (the diagnostician) structures a relationship explicitly designed to define the other person's disorders; this other person is inevitably regarded as the object of diagnostic evaluation. This relationship can be considered from various points of view; for instance in the domain of social "power", it is a relationship configuring a *dependency* established between the one who is diagnosed and the one who carries out the diagnostic procedure. It is the same social power that culturally defines the relationship between "patient" and "physician". This dependency cannot be explored because it is *acted out* within the diagnostic procedure itself. The relationship envisages a marked asymmetry in power between the one who "knows" and has the categories for the diagnosis, and the one who "doesn't know" and can do nothing but accept what he is offered or what is arranged in the expert's diagnosis, even without any direct, explicit communication addressed to him.
The diagnosis concerns the other person, not the relationship. This must be clearly stressed if one wants to avoid falling into pointless lies. And the characteristics that are found in the other are underlined without any reference to the relationship: they are stigmas that concern the other.
An example?
"For a psychodynamically oriented clinician, for instance, recording the presence of a considerable number of narcissistic traits may be enough reason to hypothesise that the person in question tends to resort to defence mechanisms of idealization, disparaging, omnipotence, splitting, projection and projective identification, has a borderline personality structure and may respond satisfactorily to psychoanalytic psychotherapy with an expressive orientation or to full psychoanalysis (see, for example, Kernberg, 1984)." (Gazzillo, F. & Maggioni, D., 2003).
Here "recording" clearly shows the "objectivity" expected of a finding which, if experienced in the relationship, necessarily entails the involvement of both the protagonists in the relationship itself. Similar considerations could be made about "respond satisfactorily to psychoanalytic psychotherapy", where the patient's choice disappears in a prescription dictated by the empirical finding.
Let us look further into the same article:

[5] In meetings with psychotherapist colleagues, I suggested a testing "criterion" for psychotherapy work: the fact that the patient keeps returning to the psychotherapist, session after session. This statement may seem naive and misleading to some. I think one should consider it. Perhaps we have not yet identified the symbolic reasons for this "patient return", session after session; on the other hand, if this fact is considered apart from obligations and duties, it has an amazing force which deserves to be understood.

"Attributing a diagnosis can also serve to soothe the anxiety one feels before a person one knows nothing about and who has come in search of help. But while, on the one hand, knowing that that person presents a particular kind of "disorder" with a name and characteristics recognized by a professional community may be a source of reassurance about one's own competence, on the other it may reduce the open-mindedness needed to understand the sense of a person's various psychological characteristics, inevitably unique, complex and impossible to simplify." (Gazzillo, F. & Maggioni, D., op. cit.).
Let us think about the aim of "being reassured about one's own competence", which can be facilitated by the diagnosis. It is obviously an aim on which the diagnostician could question himself, looking at his self-esteem, his professional identity and the meaning of a praxis that clearly imitates the medical practice, carried out to achieve personal reassurance and to recover a credible professional image. But the alternative for our authors is still the diagnosis: "understanding the sense of a person's various psychological traits….". No mention, not even the slightest, of the relationship.
It is in this view of diagnosis that we are offered the use of SWAP-200 of Westen D., Shedler J. & Lingiardi V. (2003). This interesting tool, which enables the "other's" personality disorders to be diagnosed through the evaluation of 200 items with a relevance score, is specific to the patient that one sets out to diagnose. It is usually said that to apply SWAP-200 it is enough to have just a few interviews with the person one wants to diagnose and about which one "knows nothing" in the words of Gazzillo and Maggioni. In their work, the latter present some examples of the items that are used to describe *projective identification:*

"116: Tends to see his feelings and impulses as being unacceptable in *others*[6] and not in him/herself".
" 76: Behaves so as to arouse in *others*[7] feelings similar to those that s/he her/himself is feeling (eg. when s/he is angry, s/he acts in a way that arouses anger in others; when s/he is anxious, s/he acts in a way that induces anxiety in others)".
"154: Tends to arouse extreme reactions and strong feelings in *others*[8]".

One starts to wonder: who are the "others" systematically evoked in the items in question? Aren't they perhaps the psychologist or the psychiatrist who conducted a few interviews with the person to be diagnosed in order to compile the SWAP-200? Or is it based on the declarations of the "patient"? Why does the score concern tendencies or behaviours described as *stable* characteristics of the person diagnosed? Moreover, is it possible to identify the relational dynamics evoked by the emotional symbolic dynamics mentioned in the items? Is it believed perhaps that projective identification is an event concerning the "other" being diagnosed? The other who is characterized for instance by his tendency to "see his own feelings in others"? With the tendency of the interlocutor being diagnosed to "arouse feelings similar to his own, in others", to "arouse extreme reactions and strong feelings in others"? What does it mean to experience all this *in the relationship* with the person one is supposed to diagnose? What does it mean to feel all this *within the relationship* with the person one has accepted to have in therapy?
Perhaps whoever goes through the experience of the relationship, and tries to report it, will understand the difference between one's own experience with the patient and having two or three interviews with the same person, so as to be able to give a score on the items of SWAP-200. What I am trying to say is that the diagnosis is not a "neutral act" with no emotional and symbolic meaning. *Acting out the diagnosis means accepting that specific symbolic dimensions are acted out in the therapeutic or diagnostic relationship*. While there is a cost in not formulating a categorical, dimensional diagnosis of the patient, there is also a cost in pursuing the diagnosis itself. Getting back to projective identification, we are talking about emotions that unfold *within a relationship*; projective identification does not exist as a descriptive connotation of the "other"; projective identification exists as a characteristic of relationships, first of all, of the relationship between the clinical psychologist and the person who comes to him with a problem. Making a diagnosis means constraining, within the study of a specific person's disorders (defined by the

[6] My italics.
[7] My italics.
[8] My italics.

diagnostician), what this person may know about himself through the emotional symbolizations connoting his relationships, in particular that with the clinical psychologist; these relationships, we must remember, are affected not only by the characteristics of the individual, but also by his interlocutors and by the context in which the relationship comes about. The diagnosis therefore tends to decontextualize specific psychological dimensions, to consider them as stable features of the personality, characterizing a decontextualized individual.
It is understandable that this need to diagnose is present in the cognitivist approaches of psychotherapy. It is far less understandable for those who claim to follow psychodynamic theories and techniques both in research and in practising clinical psychology.

A broader view

This editorial, in synthesis, tries to point out a cultural orientation, found from politics to psychotherapy, which sees less and less attention being paid to the symbolic dimension of relationships and which seems to want to replace the emotional symbolic interpretation of events with an empirical attitude. The reasons appear to be varied and hard to pinpoint. But some hypotheses can be made. At the outset we talked about the difference between symptoms and problems. I believe that to "see" problems, manuals and categorical scales are not enough. What is needed is a historical and cultural frame of reference within which to contextualize the problem. Amartya Sen, in his essay "*The Other India*" (2005), deals with the serious problem of fairness in his homeland. It is a country which is also the subject of many of his works on economics. He says that belonging to disadvantaged social classes is a clear problem of fairness. He also says that other factors in the lack of fairness are related to *gender* - underlining the inequality of women in India - to membership of a low *caste*, to emarginated or minority *communities.* The Nobel prizewinner stresses that these aspects cannot be studied and then "treated" separately with economic intervention. He strongly underlines that the interaction of factors of inequality is more important than the single factors themselves, taken one by one. The problem is therefore not the economic diagnosis of the different situations, but their connection in contexts that need to be understood, in order to intervene so as to promote fairness. But "promoting fairness" is a value, historically defined and culturally oriented. The correction of single "deficits" can cause damage; it can, as Sen says, see complex situations succumb to "friendly fire".
I believe that the progressive drain of possible *missions* for Clinical psychology, in Italy above all but also in other European countries, may encourage the practice of correcting deficits, thus neglecting the goal of promoting development. A little like what is happening in the political world.
This is, at the same time, a cultural crisis that is spreading all over Europe. In France they have long been talking about a "crisis" in culture and in creativity; a flattening of values and of projects seems to be the result of economic growth in many European countries, when such growth is not supported by a *vision* that has a cultural character and is defined by specific value systems. In such situations, a vaunted or real "empirical technicalism" can serve to reassure when faced with emptiness and identity crisis. And it can generate false certainties.

References

Gazzillo F. & Maggioni D. (2003), *La SWAP-200: un ponte tra ricerca e clinica, diagnosi e formulazione del caso* [The SWAP-200: a bridge between research and clinic, diagnosis and the case formulation]. Retrieved from: http://www.psychomedia.it/asp/setting/articoli/gazzillo-maggioni

Ginzburg, C. (1986). Miti Emblemi Spie. Morfologia e Storia [Myths, emblems and spies. Morphology and History]. Torino: Einaudi.

Rafanelli, C. & Fava, G.A. (2006). La valutazione dei fenomeni clinici tra qualità, quantità e giudizio clinimetrico [The assessment of clinical phenomena between quality, quantity and clinimetric judgement]. *Rivista di Psichiatria*, 41, 137-149.

Sen, A. (2005). *The Argumentative Indian*. London: Penguin Books Ltd.

Westen, D., Shedler, J. & Lingiardi, V. (2003). *La valutazione della personalità con la SWAP-200* [The assessment of personality by the SWAP-200] Milano: Raffaello Cortina.