Practical training in the health facilities and mental health centers

by Renzo Carli

Introduction

In the sixties and seventies every psychological intervention aimed at promoting change in behavior, designed to trigger thinking about emotions and awareness of relational dynamics, in order to underline the emotional component of relations with the objects of the situation, was considered "psychotherapeutic". A psychotherapeutic aspect was therefore implicit in every intervention by the psychologist, both in schools and in businesses, in health systems and in operations with the disabled, with teenagers and with the family.
Later, in the eighties, psychotherapy split from psychology and was identified with the practice of the treatment carried out by the psychoanalyst, the systemic or cognitive therapist. It was the beginning of the era of the schools of psychotherapy, which was later established with the law founding the psychology profession, Law n° 56/89: with article 3, this law officially introduced four-year training of psychotherapists in the different courses offered by the private schools. A separation then occurred between (clinical) psychology on the one hand and psychotherapy on the other. The difficulty of professionally qualifying in psychology, due largely to the poor professional experience of the university teachers when the Degree courses were set up, and to the great influx of psychiatrists and psychotherapists into the teaching of psychological subjects, did the rest: what followed was a progressive deterioration of the psychologist's professional role, and the emergence of the belief, still deeply rooted in many psychology graduates, that the psychologist's only professional opportunity was to "become" a psychotherapist in one of the many movements and the numerous models adopted by psychotherapy in the private four-year schools.
This evolution of psychotherapy, on the other hand, does not involve a practical training activity[1]: in psychoanalysis, which has been for a long time the most common form of psychotherapy among the psychologists in our country, the training is based on the pair, "personal or teaching analysis and supervision of cases treated psychoanalytically by the trainee". Supervision therefore replaces the actual practical training; the student is trained in his private study, with no contact with organised work contexts, from school to health services.

But let us take a step backwards. In 1976 there were the first graduates in psychology in Italy. In 1978 law n° 180 was passed. Until the early nineties, when the private four-year psychology training schools were officially recognised, where did psychologists get their professional training? This does not seem irrelevant. Most of the young psychology graduates of the time encountered psychological work in the local health facilities, which had been founded by Law 180. Did they practise psychotherapy in these facilities? Certainly not, if by psychotherapy we mean what is defined by the psychotherapy school and their various courses. Those young psychologists that wanted psychoanalytical training went to the *Società Psicoanalitica Italiana [Italian Psychoanalytic Society],* which was then not very willing to accept psychologists; or they went to some other psychotherapy association in the psychoanalysis area. Psychotherapy training later also saw systemic, behaviorist and then cognitivist schools of psychotherapy becoming active.
Social health structures were the reign of the enthusiastic single operator, with a levelling of professional distinctions between social workers, nurses, psychologists, trainers: under the guidance of psychiatrists, trying to put the dictates of the 'Basaglia law' into effect, they worked to keep patients in their families and to prevent psychiatric crises in those who were to be reinserted into the social fabric. But we will return to this soon.

[1] The Italian 'tirocinio' (practical training) derives from the Latin term *tiro, tironis*; *tirones* were young soldiers, recruits inexperienced in the art of war. The trainee, also etymologically, is an 'inexperienced' person that has to be introduced to training.

The work of putting the 180 into effect came with the reintroduction of patients into their own families, or their placement in half-way houses, residences, therapeutic or rehabilitative centers for those with no family to return to, in the long journey of leaving the Psychiatric Hospital. This had, in the sense recalled above, profound psychotherapeutic ramifications. It was after all an intervention that was not related to any of the theories of technique typical of the schools of psychotherapy; it was not based on setting and established working conditions, but its praxis came from the goals pursued.
In the nineties, things changed considerably in the mental health services. Progressively, the psychiatric maintenance of "serious" patients shrank to the rooms in the Mental Health Centers scattered over the area. Apart from this maintenance work, done with psychotropic drugs and psychiatric advice on how to live, there was the beginning of psychotherapeutic work. This psychotherapy was addressed to a client-base that was new compared to "psychiatric" patients, generally called clients with "common mental disorders". The reasons for this change and this appearance of psychotherapy in mental health, with the forms and rules of "private" psychotherapy, are still not very clear. The fact remains that this launch of psychotherapeutic work allowed young[2] psychotherapy trainees to find a place for their practical training also in the local mental health services. This practical training was then subjected to the rules governing private psychotherapy schools, with practical training having to be done in facilities where psychotherapy is carried out and where there is a psychotherapist as training supervisor. This has created a deep-seated contradiction between the orientation of the schools, often narrowly defined by the conditions of the technique underlying the psychotherapy the trainees are learning and by the goals involved in this technique, and the experience of practical training which, due to structural and relational factors which we will examine here, offer forms of psychotherapy strictly connected to the context and to the goals associated with them.

The question we are asking at this point is the following: can the psychotherapy practised in the health services be equated with the psychoanalytical, systemic or cognitive psychotherapy in which training is given in the private schools? If this is not so - and there are many indications that there are profound differences between "private" psychotherapeutic practice and what we can call "public" practice - what exactly is the difference?
There is more. In relation to the possible differences, what can be the use of practical training in the public sector, if the professional prospects pursued by the trainees lie in private activity? What is the meaning of "public" and "private" in the psychotherapy area, and in particular in psychoanalytically-oriented psychotherapy? These are the questions to which this talk intends to offer some answers.

Psychotherapy and context

In 1992, I founded and for four years directed the Four-year School of Specialization in Clinical Psychology in the Faculty of Psychology at the "Sapienza" University in Rome. The aim of that school was to train psychotherapists that could work in the national health

[2] Law n° 56/89 revolutionised the psychology profession. The law, introducing the psychology profession, separated the activity of a psychology graduate described in article 1 of the same law ("The psychology profession includes the use of tools for knowledge-getting and intervention for prevention, diagnosis, enabling, rehabilitation and support activities in the psychology field, addressed to people, groups, social organisations and the community") from that of psychotherapist, described in article 3 ("The practice of psychotherapy requires a specific professional training, to be carried out after a psychology or medical degree, with courses of specialisation of at least four years envisaging an appropriate training in psychotherapy, introduced according to the *decree of the President of the Republic 10 March 1982, n. 162*, in schools of specialisation at Universities or schools recognised with the procedures as per article 3 of the above Presidential decree"). Psychotherapy soon became, due to complex factors widely discussed at the time, the "one and only" profession to which psychologists aspired.

system and more generally in social health facilities. This aim was successfully achieved, if we consider that the vast majority of students attending the school in the first four years, after finishing, entered the health service, and many of them gained a reputation for competence and professionalism. Then things changed and the school took on new features, losing its training specificity and becoming a place for research serving the interests of a group of teachers, without its own specific professional character. That is why I decided to devote my university work to basic training: with some colleagues I organised the degree course in "Clinical Intervention" of which I was head from its founding in 1999, and for ten years I accompanied the course in its various changes, up to the latest reform under law n° 270. I gave up the presidency of the Degree course in Clinical Intervention a couple of months ago. Three years ago, in view of the impossibility of reorganising specialist training in the university designed to promote psychological competence for the social health service, I set up the school of Psychosociological Studies, this time in the private sector with a group of colleagues who share the project of training psychotherapists capable of working in the public service.
Our school of Specialisation "Psychoanalytical psychotherapy: Clinical psychology intervention and analysis of the demand" sets itself a precise objective, which we will quote from the mission statement[3]:

> The Course intends to train psychoanalytically-oriented psychotherapists who can practise individual or group psychoanalytical psychotherapy in various social contexts: from the National Health Service in its different branches, to schools; from businesses to organisations assisting "needy" individuals (the elderly, disadvantaged youth, substance abusers, people of "other" cultures and from non-EU countries); from religious, military or prison organisations to those working in the third sector.
> This involves a twofold level of training: on the one hand, training in psychoanalytical psychotherapy practice, on the other the knowledge and practice of the intervention in the cultural and structural dynamics within which psychotherapy is carried out. The two areas of training call for a profound and successful process of integration. This also involves a form of psychotherapy designed not just to correct deficits but to promote development.

It is therefore easy to understand the importance placed by our School on practical training in the general and mental health facilities: they are the best place to learn psychotherapy in an organisational system that combines the patient's problems with the relationships between patient, psychotherapist and context.
I would like to briefly examine this statement, to look more closely at some of the ways the context *intervenes* in psychotherapy practice in the health services and mental health centres.
A brief premise: in "private" psychotherapy practice, the request for psychotherapy addressed to a specialist because of his/her professional qualification (psychoanalyst, therapist, systemic therapist, cognitivist therapist etc.), is usually followed by an analysis of the feasibility of psychotherapy, which is done through a few interviews which enable a decision to be made based on the psychotherapist's availability and the possible therapeutic work envisaged. This prediction is based on the characteristics of the relationship between the potential patient and the psychotherapist in the few preliminary conversations. The "private" demand, therefore occurs on the basis of the psychotherapist's qualification: *"I would like to experience psychotherapy with you"* means that the pragmatic field of the psychotherapy and the choice of the psychotherapist is already envisaged. In private practice there is a greater tendency to choose the form of psychotherapy rather than to make a deep analysis of the dynamics of the demand. To enter psychoanalytical psychotherapy, in other words, it is enough to declare one's interest in a psychoanalytical treatment and one's intention to "have" that experience; it is not necessary to define the disorder, share one's suffering or distress with the psychoanalyst; it is not necessary to complain of specific emotional symptoms (anxiety, panic, depression, anger) or particular

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The entire document "Fondamenti teorici e metodologici della scuola" can be consulted on the site: http://www.spsonline.it/Specializzazione01b/FondamTeorici.html

behavioral problems (eating disorders, difficulty in relating affectively, sexual problems, substance abuse, specific phobias that have a limiting effect on behavior), just to give a few examples. Those who ask for a psychoanalytical experience obviously present some problem; but the decision about the psychotherapy is taken in relation to the feasibility of the treatment, rather than to the reasons that have brought the person to the psychoanalyst. Hence the possibility of a psychoanalytical experience even for those whose only symptom is that they want to become psychoanalysts and enter psychoanalysis due to an obligation dictated by the training facility they are going to attend.
Things are different in mental health facilities, where the admission process usually obtains the basic information needed for *referring* the patient to one of the psychotherapists working in the service. The admission process decides the reason for the acceptance of the demand and assigns *that* patient to *that* specific psychotherapist. Here the patient, or someone speaking for him, presents a problem, not the intention to have a specific psychotherapeutic experience; it will be the admission process, based on criteria that differ each time, that decides whether to accept the demand and start the psychotherapy, offering the patient the particular psychotherapist that the admission process chooses. It is often believed that the disorder presented and described by the patient, as well as the diagnosis of these disorders, formulated using some psychopathology index, are reason enough to give psychotherapy a meaning and a justification: the patient experiences feelings of marked anxiety, suffers from panic attacks, presents an acritical passive dependency towards a parental figure, which is enough to justify the *referral* to the psychotherapist. In the perspective that we use, this is a typical situation of collusion between mental health center admission, patient and psychotherapy service. All this has profoundly changed the aims and practices of mental health. It is no longer thought that these services are devoted to those who suffer from mental illness, with all the stereotypes and prejudices attached to that. Instead, it is thought that the most varied problems occurring in the emotional life of people and families can be dealt with through the psychotherapists of the health service. This has given access to psychotherapy to a category of the population that would not have been able to enjoy expensive “private” psychotherapy. It would also be interesting to study the function played by the psychotherapy of common mental disorders in preventing psychiatric crises. But on this, the little literature available is unreliable.

Summing up: in “private” psychotherapy the patient asks, based on certain problems, to have a psychotherapy experience with a specific psychotherapist, with a definite psychotherapy technique (psychoanalysis, cognitivist therapy etc.); in psychotherapy in the mental health services, the patient presents a specific problem and waits for the admission facility to decide on his access to psychotherapy, without knowing either the psychotherapist or the technique he/she follows. Furthermore, the experience of psychotherapy, in the private sector, will depend on the technique used by the psychotherapist (ranging from several sessions face to face, to up to several years’ work on the couch); in the public services, on the other hand, the experience will be tied to the diagnosis made by the admission facility, and by the rules governing the psychotherapy practice in that particular service. These are therefore structural constraints that depend on the diagnostic models used, on the theory of the technique adopted and on the rules the service has set itself.

A digression on this point. Our school bases its training on the analysis of the demand. Analysis of the demand[4] is a construct that is an alternative to the diagnosis and the clinical psychology intervention based on the diagnosis[5]. In analysis of the demand, instead of referring to the patient’s clinical features, the reference point is the relationship with the psychologist and the symbolic dynamics characterising it. It is therefore totally misleading to refer to the construct of analysis of the demand only to codify it as implicit or explicit, correct

[4] Carli, R., & Paniccia, R.M. (2003), Analysis of the demand. Theory and intervention in clinical psychology. Bologna: Il Mulino.
[5] On this, see: Carli ,R. (2008), The report and the diagnosis, Rivista di Psicologia c
Clinica, 2, 154-170.

or erroneous, and so on. If the demand is defined using evaluative or diagnostic parameters, a construct concerned with relating is transformed into a "diagnostic" construct where the diagnosis no longer refers explicitly to the person, but it is the diagnosis of the demand that the person presents to the clinical psychologist.

Yes, but can the psychotherapist working in the mental health centers legitimately ask and ask himself: what does the patient expect from psychotherapy? What makes the patient accept the offer of psychotherapy and prepare to relate to the psychotherapist? The answer to these questions cannot lie in the disorders the patient narrates in the admission interviews, at least for psychoanalytically-oriented psychotherapy. The "disorders" or "problems" the person brings to the service are, as we have seen, the *pretexts* to enter psychotherapy. It is in fact a mental health service which the clients see as being devoted to the treatment of "psychic disorders": this explains why people initially present their "psychic disorders". By this, I do not mean that the problems presented on admission are false or a mere pretext; quite the opposite. But the expectation of psychotherapy is the expectation of a relationship, not of a prescription for medication or a treatment related to the body. What is involved in the case of psychotherapy, is the way the patient symbolises the relationship with the psychotherapist. This is a factor that is very important for us: the medical relationship envisages a direct and necessary relation between the diagnosis of a disorder (such as kidney failure) and medical intervention (to continue the example, the prescription for dialysis). It is taken for granted and acritically accepted that the presence of a bodily dysfunction must necessarily entail medical intervention. The patient has to recognise the *necessity* of the treatment, if his disorders can be diagnosed by the medical system, within limits that in extreme cases, are the center of heated debated (from life support for protracted vegetative states to living wills). Whoever ventures into the dynamics of the diagnosis is obliged to acritically accept (though informed of the facts) the medical acts setting out the treatment, and is therefore in a state of passivity towards the intervention univocally decided by the doctor. Psychiatry, being a branch of medicine, works in the same way as the other areas of medicine.

The same cannot be said of psychotherapy, and more generally of the psychological intervention. Psychotherapy, and specifically psychoanalytical psychotherapy, necessarily requires the agreement of the patient. This agreement does not lie only in the production of fantasies or in the unfolding of specific cognitive structures, but also in the collusion with the psychotherapist, in the dynamics of development of thinking about what is offered emotionally, or acted out, in the context of the relationship. This aspect is often underestimated both in "private" psychotherapy and, which is what interests us here, in psychotherapy in the health services. We stress the difference between what we are saying and the construct, often confused and not very useful, of working alliance.

The latter, if we use the definition given by Bordin (1979)[6], concerns a reciprocal agreement between patient and psychotherapist, in reference to the *Goals* of the change that is sought through psychotherapy, to the *Tasks* that may help to achieve these goals and to the *Bonds* established that serve to maintain the collaboration, on the part of both the patient and the psychotherapist, as well as bringing into play confused affective dynamics of warmth and understanding. It is interesting to notice, in a recent book on diagnosis[7], that the relationship involved in the diagnostic process is seen solely in terms of the "diagnostic alliance": a paraphrase that immediately suggests the "therapeutic alliance". The therapeutic alliance seems to be closely connected to the question of power in the therapist-patient relationship[8], as well as the diagnoser-patient one. This implies that the diagnostic relationship is experienced, in these theoretical constructs, as a relationship of power. Analysis of the demand seeks to place the emphasis on the symbolic relationship between patient and

[6] Bordin, E.S. (1979), The generalizability of the psychoanalitic concept of the working alliance, *Psychotherapy: Theory, Research and Practice*, 16, 252-60.

[7] Dazzi, N., Lingiardi,V., & Gazzillo, F. (2009), *La diagnosi in psicologia clinica [The diagnosys in clinical psychology"*. Milano: Raffaello Cortina Editore.

[8] Carli, R. (2009), Deconstructing and reorganizing the construct of Working Alliance, *Rivista di Psicologia Clinica*, in this issue.

therapist, not on the power dynamics that allow one to classify the other person into psychopathological categories. This proves of very little use to psychotherapy and, at the same time, extremely harmful in the influence it can have on the therapeutic relationship.

What we are underlining entails the symbolic-affective sharing of the relationship and the possibility of suspending action, to develop emotional thought about the fantasies that the psychotherapeutic relationship evokes in the patient and in the psychotherapist. This serves to promote the patient's development. We will return to this statement below.
Let us think, as an example, of a case where a patient is referred to the psychotherapist in a public health service because, after an operation on the brain, he presents a left paresis accompanied by events of depersonalisation and anaffectivity. The doctor that follows the post-operative progress finds it appropriate to ask for the intervention of the psychotherapist. The question we can ask ourselves is this: the doctor has good reason to refer the patient to the psychotherapist; can the latter, on the other hand, legitimately ask himself what the patient expects from the psychotherapeutic relationship with him? Unless this system of expectations is examined in depth, it is impossible to start psychotherapy. Some might think, naively or aggressively, that the answer is self-evident: the patient wants to get well, he is making a request for health. Yes, but this expectation, obviously legitimate, can justify the passive acceptance of the medical intervention; it is far less useful in establishing a psychotherapy situation and a participation in the process of psychotherapy. An important task for the psychotherapist in the relationship leading to psychotherapy is to ask himself about the priority characterising the patient's agreement to relate with him. This priority can be identified in the patient's emotional symbolisation of the psychotherapeutic relationship, in the collusive dynamics with the psychotherapist and with the context in which psychotherapy is arranged. In our case, the referral to the psychotherapist is due to the doctor's concern that the neurosurgery had caused somatic damage (paralysis) as well as psychic damage, which it was important to ascertain and treat rapidly. On this basis, the patient accepts the prescription for psychotherapy and similarly the psychotherapist, too, agrees to work with the patient in analysis. Let us now think of the encounter between psychotherapist and patient, alone with their emotions and their emotional symbolisations of the relationship. It is on this phenomenon that work can be started, and it is important to grasp the symbolic priorities that the patient brings to this relationship. These symbolic priorities cannot be predicted by the psychotherapist on the basis of the referral, and they are likely to have little to do with the concerns of the referring physician.
This broaches a problem of great interest, in the area of psychotherapies carried out with the health service system: that of the *referral*.
Think for instance of the case in which a psychiatrist of a Mental Health Center has a middle-aged woman in therapy, with husband and children. Think of the decision reached by the psychiatrist and the woman in therapy, about the usefulness of a psychotherapeutic experience also for the husband, who has a difficult, ambiguous relationship with the daughters. On the psychiatrist's advice, the woman invites her husband to go to the service to ask for psychotherapy. The husband agrees, to "keep her happy", he says, and he goes to the health service where he is welcomed by a trainee psychologist who carries out the initial conversations. The reason this person was "referred" to the service by his wife, is not the same one that the man discusses in the first interviews with the trainee. The latter presents the case to the team where it is also discussed by the psychiatrist who has the wife in therapy. It is underlined that, in the relationship between the trainee and the man, the *real* problems reported by the wife and based on precise facts, are now not emerging. This is a problematic and in some respects, difficult, situation. The trainee is experiencing a relationship where it is up to the person he is working with to decide what to say and how to symbolise the relationship. But he also finds himself dealing with the "orthopaedic" expectations of the therapeutic couple that gave the referral for the case. Think of the case of a young woman who is diagnosed by the psychiatric service as having paranoid schizophrenia and who with this diagnosis, is sent to a trainee doing his practical training in the service. What is the sense of psychodynamically-oriented psychotherapy when the

relationship between patient and psychotherapist is marked by such a diagnosis? How can the act of diagnosis interfer in the fantasies that come to the mind of the trainee psychotherapist or of the patient, but above all, in the relationship between the two? With these examples we want to emphasise that if psychotherapy practice is carried out in a mental health service, it takes the form of an event inevitably connected to other events and to specific expectations characterising the network of relationships in which that psychotherapeutic relationship is unfolding.
The referral in the mental health services can be based on a problem presented by the patient, transformed into a diagnosis that can justify sending the patient to psychotherapy. This diagnosis on the other hand has the power to orient the psychotherapist's mind, to motivate his goals, to organise the expectations about the outcome of psychotherapy. I remember a young colleague to whom a teenager was referred, diagnosed with bulimia; the girl asked the colleague to deal with her relational problems, but the psychotherapist's mind was "filled" with the question of the eating disorder and the urgency of intervening and getting results on that point. However, the teenager's priority was different, and could be linked to the relationship with the psychotherapist by explicit symbolic contents.
Psychotherapy in the mental health services has a setting that is not decided by the negotiation between psychotherapist and patient, but follows the rules laid down by the service, binding both. This is important if we think of the frequent attacks on the setting that take place in private practice on the part of patients. There is often the request to have fewer sessions, to change the method of payment, to change the time. In psychotherapy where the setting constitutes the only aspect of "reality" in the therapeutic relationship, these attacks, especially with psychotherapists at the beginning of their psychotherapy work, involve problems in managing the relationship. In the health services, on the other hand, the setting is often linked to a "third" dimension in the psychotherapy relationship, the rules or customs of the health service. For the trainee, this forms a sort of fantasy of dependence on the management of the health service, often in collusion with the patient.
Referral, diagnosis, time limits on psychotherapy, the setting, the relationship between the psychotherapist and the other structures of the service, are some of the aspects that orient the goals of psychotherapy in the general or mental health services, and contribute to defining how they work. To us it is important for the trainee to be thoroughly aware of these factors that shape the psychotherapeutic experience in public health facilities: it is only in this way that these features can become a resource for psychotherapy and not a limit to models rigidly adopted and therefore incapable of considering the limits and the resources of the context. It must be stressed that such limits and resources, with different characteristics, are also in operation in "private" psychotherapy.

Psychotherapy in the SPDC and in therapeutic and rehabilitation centers.

I would now like to ask what kind of psychotherapy can be experienced by our trainees when they come into contact with psychiatric patients, for instance in an SPDC, a therapeutic or rehabilitation center.
Let us offer a few considerations about this. Usually we think of psychotherapy as a praxis codified by specific techniques, differing in the various theories of technique and formalised, as we said, in the training given by different schools of specialisation in psychotherapy: psychoanalytical, systemic, cognitivist technique, etc. The history and the experiences of these areas of psychotherapy lead directly to a "dual" conception of psychotherapy: there is a patient (real or potential) who experiences in his work, school or more often family life, some problems which he thinks may be helped by the psychotherapy experience. He therefore contacts a psychotherapist who will use with him the skills of his training. Psychotherapy, in this perspective, is a practice that originates from the problems experienced by a specific person, as well as from the professional training of a psychotherapist who deals with these problems in a dual relationship (either family, or group, but the dual dynamic does not change), designed to examine the problems in depth

or solve them. The dual conception emerges form two fundamental conditions that structure psychotherapy: the *individual* experience of the problems presented by the patient and the psychotherapy technique applied by the therapist, which necessarily involves an individual relationship with the patient. It is interesting to notice that in the perception of the "common people", there are two hypotheses about the demand for psychotherapy: one sees the family as the weak, unprotected link in a highly competitive social system that is transgressive, violent, lacking rules, and thinks that the psychologist can intervene in defence of this "fragile" component of the system of living together threatened by the survival of the strongest; the other thinks that only disturbed people go to the psychotherapist, being the only sick component in a "healthy" and admirable social system[9]. The second way of looking at psychotherapy systematically considers "others" while the first refers to oneself and one's own experience. In the first case, therefore, psychotherapy is placed between the social system, the family and the individual. But, as an experience, it always concerns the single individual.

Things are different for mental illness, for various reasons. One important reason is the social and contextual origin of mental illness. The psychiatric crisis, in the great majority of cases, is a *crisis of the system of living together*. Admittedly, it is a crisis where the protagonist is the person who is mentally ill, who sees his *deuteragonists* as the other participants in social relations: the various components of the family, the apartment block, the workplace, and friends. Unless there is a crisis of living together and of the systems of collusion that support it (rules of the game, neo-emotional scripts, role dynamics, systems of expectations in relationships), a psychiatric crisis rarely occurs. The latter, therefore, can be described as the medicalisation (psychiatrisation) of a crisis of living together, affecting one of the participants in the system of living together. The medicalisation of the crisis, is known to be the 'solidarity-type' alternative to criminalisation; in the latter case, the judicial system replaces the medical one, to judge the person responsible for an event involving the transgression of the rules of the social game

Before the 180 law, those involved in a crisis, once psychiatricised, were admitted to a Psychiatric Hospital where they went through a great range of vicissitudes, culminating in being released and admitted repeatedly with ever shorter intervals between episodes, until generally the disorder became chronic, leading to the irreversible hospitalization of the individual. I recall the first page of the clinical records at the Verona Psychiatric Hospital in the early sixties, where the succession of admissions and releases, for a "medical" culture that seeks the reversibility of the pathology, was embarrassing to say the least.

With the 180 law, Italian psychiatry would try for nearly two decades to bring into operation the closure of the Psychiatric Hospitals. The main strategy was to give the patients back to their families, which had (as the main place of the crises) wanted "to get rid of them". There was at the time a massive return of the mentally ill and the dominant culture of the period judged "guilty" those who did not want to accept into their social system the "different" - from the disabled to the mentally ill, from the anarchic to the drug addict, from the social misfit to the tramp to the non-EU immigrant. Only those without a family to return to, were sent to halfway houses, therapeutic centers of lodgings. The main aim of psychiatry in the local area in the two decades following the passing of the 180 in 1978, was to avoid failures in this return to society. For this purpose health workers (for a long time "single health workers", with no differentiation of profession, training, role in the health system) tried to facilitate a new system of living together for the mentally ill. Use was made of psychotropic

[9] See the research I carried out with my research group to analyse the demand in psychology: Carli,R., & Salvatore, S. (2001), *L'immagine della psicologia. Una ricerca sulla popolazione del Lazio*, [The image of Psycology. A research on population of Latium. Roma: Kappa; Carli, R., Paniccia, R M., & Salvatore, S. (2004), L'immagine dello psicologo in Toscana [The image of psychologist in Tuscany], *Psicologia Toscana*, 10, 1, 7-100; Carli, R., Paniccia, R.M., Bucci, F., Dolcetti, F., & Giovagnoli, F. (2009), La domanda nei confronti della pscologia e l'immagine dello psicologo nella popolazione toscana [The demand toward psychology and the image of Psycology in Tuscany], *Pscologia Toscana*, 15, 2, 5-24.

drugs, obviously, but also of interviews with the family members, home visits by psychiatrists, nurses, psychologists and social workers, while the consultation facilities in the local areas were being organised to deal with the more serious cases. In these facilities, with the passing of time and with the arrival of psychiatrists or psychologists trained in psychotherapy in private schools or organisations, psychotherapy also began to be provided. This provision, as I said above, was not addressed to people with serious mental illness but to the new demand (common mental disorders) which in the meantime, thanks to the spread of psychotherapeutic culture, was growing. These psychiatrists and psychologists with two-sided training (in psychiatry and clinical psychology on the one hand, psychotherapy on the other) made a sort of split in the provision of mental health services: smoothing and facilitating the mentally ill person's return to the family, but also giving psychotherapeutic treatment to the "other" growing clientele that contacted the health services. This double function of the mental health services was consolidated for some years, until about the mid-nineties when, in Italy too, there was a drastic change in the "wind from the left" and the right-wing under Berlusconi came to power in 1994. The reasons for the rise of the right were manifold and I will not analyse them, obviously not being qualified to do so; it should however be stressed that the emphasis on law and order and the issue of security were always central to the right-wing political campaign, along with the valorisation of the family as an institution to "defend". That period saw the beginning of a sort of silent revolt in the families of mentally ill people, now organised into very active associations. This revolt rejected the weight of guilt that had for too long been the foundation of the return of patients to their families and loudly demanded a stop to the destruction of whole families due to the difficulty, often extremely painful, of coping with a mentally ill person alone with his delirium in the family. The growing strength of this protest brought Italian psychiatry before a task that until then it had avoided, at least in part: providing a different "arrangement" in society for the psychiatric patient and setting goals not just related to keeping the sick person in the family, but to the "sense" of rehabilitation of facilities where, either with therapeutic goals (therapeutic centers) or the goal of returning to society, a number of patients are grouped together and handled by a dedicated multidisciplinary team. These facilities, for various reasons including the presence of many psychologists (though with very different roles), promote aims and techniques that are no longer related to simply containing the patients, but to developing specific competences designed to achieve the self-sufficiency of the psychiatrically ill person. The "psychiatric" person is not likely to be cured; the rehabilitative intervention sets out firstly to prevent the illness from becoming chronic; at the same time, to promote his development of the skills of being with other people, which allow him to return to the family and in some cases also to return to work. This double aim is pursued with psychotherapy, along with psychotropic medication. This is not the psychotherapy based on techniques which, as we have seen, originated in recent times and is concerned with the dual relational dynamic. Here, by psychotherapy we mean the psychologist or psychiatrist's ability to use all the patients' relational vicissitudes with them, with the health workers and the management of the facility, with the family and with the context in which the facility is situated, in order to "think of the emotions" encountered in themselves and others in the various relational situations. There seem to be two main goals in these experiences of institutional psychotherapy: to help the patients take the "other person" into consideration as a being endowed with the same emotions, the same desires, the same needs as oneself: at the same time, to be aware of the rules of the game and the constraints that living together places on oneself and on others. The discovery of the "other person", in fact, can only come about in a "regulated" system of relations, and therefore governed not by norms but by rules of the game, not by constraints set by a threatening enemy judge, but by shared rules that make it possible to live together and know each other. It is important to underline that these relational matters typical of all community experiences, can be considered from a double viewpoint: the aspect referring to the structural reality, either dictated by norms or agreed on by people, and the emotional symbolic reality. For example, a patient in a center in which some of our students are doing their practical training, leaves the center to go to his sister's place, without warning and without arranging

the outing with the staff. For the latter the patient has “run away from the center”; for the patient, on the other hand, the episode is described as “going to see his sister”. To understand the point of view of the staff it is useful to remember the rules on residents leaving the center, as an event that is arranged, justified and decided with official permission; to understand the patient’s point of view it is important to grasp the sense of his seeking his sister, at that moment in his rehabilitation, as well as the disappointment in a search that could not give him the affective welcome he sought to replace the distress experienced in his relations in the center. For a structural reading of the life of the center it is necessary to grasp the rehabilitative sense attributed to following the rules of daily life and of personal hygiene, of caring for one’s personal property and those shared with the other residents (cupboard, bed, rooms). To grasp the symbolic dynamic, it is important to share the psychological models of the relationship. We proposed the idea of collusion as a model for understanding the social relationship, considered from the emotional symbolic point of view. We think that the analysis of collusive processes can be useful for understanding the relational aspects in a center, to grasp the symbolic dimensions which, after restitution to the protagonists, can be of some use in organising the meaning of relations for the residents. I feel that the trainee, not having to follow the internal rules of living in the center, may find her/himself in a privileged position to understand the symbolic components of the relationship and to establish relations with the residents based on the analysis of this dynamic. In the case mentioned above, leaving the center can be seen as the symbolic realisation of the ambiguous relationship, in the patient’s mind, between family and center: a family that refuses to keep the patient at home, a center that, at least in the intentions of rehabilitation, wants to return the patient to the family. The patient seems to anticipate the rehabilitation, the outcome of his staying in the center; the family and the center collusively reject this attempt and again insist on his staying in the center.

The mentally ill, with the closure of the psychiatric hospitals, are placed in their family or into a center. They may find this reintroduction to society highly traumatic. In this case they are admitted, either spontaneously or with a TSO, to the Psychiatric Diagnosis and Treatment Services (SPDC). This is a further context for practical training, and is very interesting since the trainee can come into contact with and experience the way psychiatry operates. While the relations between the residents in a center can have a therapeutic and rehabilitative role, things are often different in the SPDC. Here the important relationship is the one between the individual patient and psychiatric team: this relationship is aimed at the diagnosis and design of the psychotropic treatment. The context, symbolically likened to a set of mentally ill people with difficulty in relating to each other and in living together with the staff of the service, is experienced in many cases as being dangerous and lacking a psychotherapeutic role. It is interesting that in an SPDC where a young, intelligent, educated man arrives, looked after by an apprehensive mother who idealises her son’s skills and abilities, the psychiatric decision is for long-term sedation of the young man to a state of lethargy, as if to detach him from the relations in the service. The role of psychology in this health service may be to shoulder the burden of relating with the patients admitted temporarily for the pharmacological control of a crisis. Looking after the relational side means on the one hand conveying an interest in the person and in his capacity to establish relationships, albeit within the problems of the crisis. It also means being in social relationships which inevitably and ineluctably take shape in the health service: in the corridors, in the common rooms, in staff meetings as well as during psychiatric examinations. It is interesting to see that psychiatry often tends to underestimate the significance of relations in the SPDC. Think for instance of a serious patient who has been a resident for a very long time - contravening the “brief” admission laid down in the 180 – a difficult patient who acts out his delirium in his contact with the other residents, forcing the manager at times to the early release of some patients that have become the butt of the delirious patent’s aggression.Keeping such a difficult patient for a long time in the service is a good sign of how much the relations between the people populating the service are neglected for the purposes of the psychiatric treatment. It is up to the psychologist who has not yet become ‘psychiatrised’, that is, who has not yet put in place dynamics of

identification with the aggressor, to work in the relationships and give a meaning to the collusive process acted out or communicated by those participating in the context, in their experience of socialisation in the service. This is a role that the trainee psychologist can play, coming close to mental illness but at the same time safeguarding his role of developing the relationship, as a factor in the treatment.

Conclusions

For students in schools of specialisation as well as for university students, the practical traineeship represents the opportunity to encounter real situations where the psychology or psychotherapy profession is practised. For the trainees this means dealing with their own emotions in the meeting with people and situations where their "practical" learning will begin. The setting-up phase of the practical training shows the emotional modality with which the trainee relates to otherness. In this sense, the initial phase of the training, the way one meets the people in the facility where one will be working (tutor, staff, other trainees), the relationships established with the context, are for the trainees aspects of great importance in understanding their personal equations in the professional relationship. Our school devotes great attention to analysing these ways of setting up the training relationship.

The practical traineeship has two aspects that are very important to us.
The first concerns the *mission of the school* where the trainee is doing his period of practice. The trainee from our school may find two kinds of missions: one of the health service and the other of the school. If trainees are an integral part of a learning process, they cannot be detached from the contents and the training dynamics in the school. Our students' traineeship, in other words, is not an experience complete unto itself, handed over completely to the practical training facility. The students' experiences in the various contexts are analysed, compared, discussed and verified in the school. For the trainee, this means having an experience in two directions: in the health service, as a person operating internally under the guidance and supervision of the tutor; and at school, since the practical training experience is part of the models, the theory of technique and the learning process fostered and analysed within the school's training activity. It is important for trainees to develop the capacity to fit into the work in the health service, to work out the meaning of their experience, to understand the rules of the game, to adapt to the system of values, the models, and the goals the service sets itself; at the same time, it is important for them to know how to organise their thoughts on the experience of practical training, so as to compare it with that of other students and with the teachers of the school. In this perspective, the practical training involves the competence to promote, activate and communicate thoughts about the experience they have had. This is why we ask the students to systematically report on their practical training experience and why we base the assessment of the first and second year on these reports, extensively discussed during the sessions devoted to thinking about the learning process. The discussion of the practical training also involves an interest in the practical training of their fellow trainees in the group, in a learning style which, alongside direct experience, places reflection on the experiences of the whole group. In some articles[10] I have stressed the importance of the report as the expression of thoughts about the experience, an integral part of the experience itself. The school's mission, in short, lies in motivating the students to develop the experience of practical training through reporting, and the shared reflection on the various reports. This is carried out from the first contact of the individual students with the facility where the practical training is to be done. It is the analysis of these experiences that allows clinical learning, with reference to the personal way the relationship takes shape between the student and the "other reality", where one's own theory of technique will be applied and developed. Thinking

[10] Carli, R. (2007), Notes on the report, *Rivista di Psychologia Clinica*, 2, 186-206; Carli, R. (2008), The report and the diagnosis, *op. cit*.
There are also the various articles published in issues 2/08 and 3/08 of *Rivista di Psychologia Clinica*, concerning "Study Days on reporting as a method of intervention in Clinical Psychology".

about reports, therefore, does not only mean dealing with clinical experience in the strict sense, with the relationship with the patients and psychotherapy activity; it refers specifically to the phases of working out the mission and the whole set of relations between student and context.

The second feature of the practical training, seemingly obvious, is the temporary wash-back effect of the experience. A comment on this: when the school lacks a mission, the practical training can be reduced to seeking psychotherapy situations that are consistent with the guiding technique or, in some cases, to indifference towards the experience. But practical training can also build up a deep sense of belonging, of being emotionally and operatively committed in the service. This sense of belonging involves an identification with the role played in the practical training and may produce confusion in the work done, between the role of trainee and that of member of the health service. This is a problematic defensive process, being based on “as if” dynamics: one acts “as if” the membership of the school and its learning objectives didn’t exist; at the same time one acts “as if” one belonged to the health service, without actually having that role which only comes from really belonging. The wash-back effect of the practical training is possible only if it is seen as being consistent with the learning process. This learning as we have seen is based simultaneously on the experience in the health service and on thinking about the training itself, carried out at school. The wash-back effect is closely connected to the duration of the practical training in a specific facility. We think the optimal length for practical training is two years. It is a period that allows for experience not only of the classical clinical situations (psychotherapy with a few patients, thorough knowledge of the residents in the center) but also of the context where the traineeship is being carried out. The integration between clinical experiences, those with “patients” and the no less important ones with the context of the training, makes it possible to develop a competence to intervene clinically in complex relational dynamics within an institution.
The school’s mission and the wash-back from the practical training concern the practical work of the individual trainees and its analysis within the training process. There is a third element of great importance worth a ‘*last but not least’*: the connection between the psychotherapy training school and the health facilities where practical training is carried out. As we know, this is regulated by ministerial norms on the contract that makes practical training possible. I am not referring to that. I am thinking, instead, of a relationship between the teachers in the school and those managing the practical training, which can facilitate discussion of the training aims, the progress of the experience, and the reciprocal interaction between the culture of the health context and that of the training school. This meeting of cultures is undoubtedly very difficult, but it also has, I think, reciprocal importance. I have had many years of experience in the university training of psychologists. I know how difficult and under-exploited the practical training has been for three-year students and for 2-year specialist students in that time. In the degree course “Clinical Intervention” which as I said, I presided over for many years, the practical training for three-year students proved unsuccessful, almost tragi-comical in many cases. Young students told to make photocopies, to attend useless courses of local training, to watch passively, kept at a distance from the work of the staff, locked inside their own pragmatic world. The report on the practical training experience was often able to give a meaning to humiliating or profoundly negative experiences. At times the practical training of the two-year specialist students suffered the same destiny. At the same time, some of them had interesting experiences, that were able to supplement their university education with efficient training in the field. There is a great range of situations, where the progress of the practical training is seen by many students as depending on sheer luck, a sort of hopeful expectation of “hitting the jackpot”. Why is this? I do not think that is an unimportant question.

Let us go back to what was said before about psychology training after law 56/89 and the advent of private psychotherapy schools. Many colleagues that currently work in the health facilities where practical training can be done, come from very varied forms of training,

oriented to different theories and techniques, often very different from each other. What counts most is that these pragmatic approaches often have a weak link with psychology and psychological competence. Therefore in the most difficult cases there is no shared theoretical and practical basis to make sense of a practice in the field of psychology. I think that this problem is reproduced in the psychotherapy training schools, with the variegated presence of specialisations sharply divided from each other, in models that have little to do with the necessary common foundations of psychology. I am aware that this event, insofar as it occurs, cannot be attributed to those working in the psychotherapy services or schools; university training has a certain responsibility, with the lack of attention to practice shown by many areas of university teaching. The risk of all this is that in our country there is an extremely high number of psychologists (over 70,000 members of the Order of Psychologists) and that at the same time there is not a unified psychology profession, which would be able to give an important identity to those working in the field. The loss of identity is accompanied, as social psychology shows, by mutual mistrust, the devalorisation of those adopting different theories of technique, conflicts that reflect badly on the profession's credibility and reputation. Clearly it is not the whole profession that shows these problems, but the issue exists and calls for an energetic solution. The trainee encounters different problems if he finds an active psychological culture in the context, capable of differentiating its own role, or if on the other hand he finds that psychological practice is missing or assimilated into other professions, psychiatry in particular. We are back to the connection between psychotherapy schools and the cultural contexts of practical training. These contrasts are useful, I feel, to valorise the differences in perspective of clinical psychology practice, considering clinical psychology as the natural mainstream for the different psychotherapeutic and intervention perspectives, if practised by psychologists. We might be forgetting that the shared psychological training can, in debate, find the common ground in a psychotherapeutic practice even though it is based on different theories of technique. Similarly, a psychotherapeutic praxis seemingly oriented to a shared theory, may differ greatly if practised by people trained in psychology, on the one hand, and psychiatry on the other. It is obvious, however, that this does not always happen. But the basic training, as research and everyday experience show, is not irrelevant to psychotherapy or to the psychosocial intervention. I think differences are a source of wealth, not a hindrance, provided they are conscious and they are debated. Hence the importance of a debate on practical training, an issue common to those who train in schools and those who train during the practical training experience itself.

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