

For a clinical psychology as an expression of scientific sense: from the hybridization of knowledge with the medical method to its placement within a precise and rigorous operative method.

*Gian Piero Turchi**, *Michele Romanelli***

Abstract

This contribution aims at outlining a *strictu sensu* operative psychological model. Whereas in medical field rigorous and precise correspondence between operative praxis and epistemic foundations of anatomical-functional item (research object of medical model) enables operative medical model to ground on scientific sense, this issue is still open and unresolved in psychological field. For instance, medical model distinguishes diagnostic praxis in two different typologies: *certain aetiology diagnosis* and *uncertain aetiology diagnosis*. The latter typology in particular enters into the merits of clinical case and it previously qualifies as syndromic some descriptive elements referred to the part or to the function of the anatomical-functional item involved. For instance: Human Immunodeficiency Virus Infection Acquired Syndrome. Transposing this reasoning in psychological field entails running up against some cognitive holes that had and still have strong implications on Psychology action. In this field, it cannot be found any cause - as the research object has epistemic foundations of theoretical construct – and each and every clinical case should be firstly connected to an *uncertain aetiology diagnosis*. Secondly a diagnostic label could not be adopted but at most a description of a syndromic featured clinical case. Therefore, being a spuriously adopted praxis aimed at recovery - as medical model aims at – and grounded on cognitive notion of cause, it is scientifically wrongful *ergo* it is inapplicable in *psycho-logos* field. Therefore, according to the article arguments, the framework of interactionist paradigms make available the observation that – discursive and shaped in interaction - reality on which *psycho-logos* model deals with is uncertain, constantly changeable and that can be changed at every moment whatever it could be. The assumptions above described ground the definition of an operative model dealing with logos, therefore on *ways* of shaping reality. The criteria can be no longer referred to etiopathogenesis and, consequently, the objective of operative model is not recovery but rather change of discursive configuration.

Keywords: Medical Model; epistemological refection; interactionist paradigms; *psycho-logos* model.

*Professor of Clinical Psychology and Health Psychology at the University of Padua. E-mail: gianpiero.turchi@unipd.it

**Clinical Psychologist and expert on the subject of Clinical Psychology. E-mail: romanelli.michele@gmail.com

Incipit

Clinical psychology is still struggling with those issues it has faced since its origins: the definition of the object of the discipline, theoretical fragmentation, its effect on the (absence) of a shared method among the operators, the definition of an area of intervention and, last but not least, the difference it can make within the Community, namely the operative contribution to those “who ask for help” (whether individuals or institutions). This situation has contributed to loss of credibility of the discipline, therefore the debate about/on these issues – which is fundamental for the survival of the discipline itself – is still open and unresolved. This paper is based on the idea that clinical psychology has not yet moved out of the “shadow of the giant”, that is, the medical and psychiatric environment in which it originated and developed.

However it is important, now more than ever – when the hybridizations between the medical model and other models used in clinical psychology are increasingly pervasive –, that the technical and procedural (not scientific and epistemological) proposal is taken into serious consideration to finally allow clinical psychology to be assimilated into the health-care field.

Thus, what other sciences (like chemistry and quantum physics) have done, namely start their own knowledge systems from a rigorous epistemic analysis, has yet to take place in psychology. Instead, in this particular historical time (in the light of significant institutional changes brought about by recent legislation), an epistemic analysis in terms of scientific and circumstantial contributions is of great value. Indeed, if carried out correctly, it would be strategic to make clinical psychology independent, and to finally set it free from other knowledge and operative fields.

Therefore in this contribution we intend to highlight the remaining “gaps” in clinical psychology (to use the rhetorical strength of a metaphor) in terms of knowledge. We will try to outline a proposal to “bridge” those “gaps”.

When speaking nowadays of (clinical) psychology, those who operate within this discipline must bear in mind that what is required of them has changed, and will continue to change, during the uncertain progress of a community as its organization is subject to continuous and constant transformations both of a social and cultural nature (Molinari & Labella, 2007; Carli & Paniccia, 2011).

In order to question what (clinical) psychology has produced internally in terms of scientific criteria and dictates, it is necessary to promote a change within the discipline itself; a change that can answer the “new challenges” this discipline has to face, so that it will not be “assimilated” (once and for all, we believe) by other methodological and operative fields.

Towards a scientific foundation of clinical psychology

In order to produce a rigorous proposal to deal with those issues which as already mentioned have yet to be resolved and are essential for the survival of clinical psychology, we must begin with a study of knowledge and the ways in which knowledge is achieved. Taking chemistry as a comparison, we can observe how the rigor used to define the knowledge system of this science has guaranteed, and still guarantees, the product. Therefore the pragmatic effect of this rigour makes the discipline independent from other knowledge systems, and (at the same time) it is also recognised by the community, which for example finds chemistry useful to manage the needs of the people (metaphorically speaking: useful to those who “ask for help”).

We must necessarily take as our starting point an analysis of the foundations of knowledge and therefore of the epistemic status of the object of study and, consequently, of the cognitive process we use to study it, coherently with the epistemic status of the object itself. (Marhaba, 1976). All at the risk of reducing the matter to discourses that, based on common sense, are the result of mere statements and cannot interfere with the process of hybridisation of clinical psychology with the medical model.

Any discussion of clinical psychology necessarily implies a discussion of science. Discussing science implies dealing with the method that science uses to operate and offer answers. But let us proceed in an orderly fashion.

The first issue, which has already emerged and deviates from later argumentation, is the distinction between the two ways of knowing which the human species has developed over the course of history: scientific sense and common sense (Turchi & Della Torre, 2007). Both are ways of building

knowledge but, for *knowledge*, they use different assumptions and prerequisites, always based on the use of language (which is why we talk about the construction of sense).

In fact, common sense does not need to explain which assumptions of knowledge it uses – hence, its way of knowing coincides with the image of reality “provided” by touch, taste, smell, sight and hearing (though not by these alone). Scientific sense, on the other hand, has an obligation to produce a knowledge that goes beyond that linked to that image (namely that bound to perception, but once again, not exclusively this). In other words, it is necessary to clarify the cognitive presuppositions (or assumptions) used and upon which it bases its contribution.

Following the difference between these two ways of knowing, exposes the the fallacy of the distinctions between exact sciences and other sciences (which are perhaps inexact?), natural sciences and spiritual sciences, quantitative data and qualitative data (to mention some of the semantic antinomies that have been used over time). What is left are the two ways of knowing: the first (in order of phylogenetic appearance) related to common sense and linked to perceptions (“*I perceive the motion of the sun and the stillness of the earth*”) and the second, characteristic of science and observation, based on the knowledge-assumption that it fields (“*I observe the stillness of the sun and the motion of the earth*”).

The word “science” traces its meaning to the etymology of the Greek word *gnosis* (that is the *knowing-process*), because it expresses the dynamic nature of science in an appropriate way, more than in the etymology of the Latin word *scio* (that is the *knowing-status*). Therefore, “knowing what depression is” represents a proposition that expresses the possession of a certain *knowing-status* which can be assigned to a psychopathological construction (that can also have nosological evidence for certain psychiatrists). Consequently, the previous proposition does not imply a *knowing-process* which translates into theoretical and operational effects, which on the one hand might involve a precise organization of observative data (indeed the psychiatric manuals call their own discipline non-theoretical) and on the other make it possible to reach a *knowing-status* about a psychopathological construction (such as the depression mentioned above). As a matter of fact, a *knowing-status* refers to a static event that is related to a content that cannot be further investigated or described. A *knowing-status* rules out any other possibility. On the contrary, the *process* of “*knowing the depressive syndrome*” outlines the object of science in terms of movement, a path, a process, because it implies further examination of those observational data that provide a description of the so-called “depression”, thus it is about pursuing a *knowing-process* (and not achieving a *knowing-status*). This is how the knowledge of a particular element used as a research object (“depression”) entails having a track, a path, that – only in its later outcomes – generates a *knowing-status* which, in turn, cannot be present at the beginning of this process of knowledge; if not, we remain on a merely lexical level (we keep clinging to the word “depression” without referring to a scientifically-based theory “about depression”). Thus, only after accomplishing a *knowing-process*, its result can eventually become the object of a *knowing-status*. This remark represents the starting point that will be borne in mind to talk about (clinical) psychology – within the psychological field.

Hence it is necessary, primarily, to proceed with a purely epistemic consideration (about the foundation of knowledge) that places psychology within a framework which focuses on the ways in which objects of study are generated as objects of the knowing-process itself (Salvini, 1998). Thus the dividing line between scientific sense and common sense does not concern the specific contents of the discipline, but the organization of these in a set of theories and concepts, firmly based on the definition of the research object and intrinsically rigorous in the adoption of a coherent method.

Science, as a *gnosis*, has historically focused on different portions of “reality”, investigating them with different ways of knowing linked to different research objects. Nowadays the human Community has a wide range of different sciences which, despite their different knowledge systems, maintain their affiliation to a scientific dimension. The words used to name these different knowledge systems, thanks to an epistemic analysis, recall the dual property of science: they are composed of two parts, each with its own specific function. The second part, that is the suffix, indicates the way of knowing used by the science at hand, meaning the knowledge prerequisite that starts the knowing-process, and can be *-logos*, *-ica* or *-nomos*. The first part of the word, that is the prefix, indicates the study (or research) object of the discipline: for example “life” for bio-logy, “society” for socio-logy, “stars” for astro-nomy and “substances” for chem-istry.

Therefore, scientific sense is represented by a set of epistemic differences: research objects and tools

used to build the knowing system are different. Thus, the ways in which a knowing-process is triggered, and consequently from which a knowing-status (declined in operative models) is generated, are different (see below and see Salvini and Galieni, 2002). Consequently science is “a way” of knowing and not “the way” of knowing (which would become true and unquestionable, aimed to the verification of the “real” presupposition, as it is unique and determined once and for all).

To continue, we need to highlight that the ways of knowing used by science (*-logos, -nomos and -ica*), are constructed by means of the use of a language: as a matter of fact, it is only through language that science builds the structure of its assertions, determines the principles that it fields regarding the object that it investigates, explains the theories and the research methods that it uses. Throughout human history, our species has provided two types of language, both of which are used to produce the assertions of scientific sense: the first is called ordinary (used by the community of speakers) and the second is called formal and is used by some sciences (meaning those sciences that use *-nomos* and *-ica* knowledge systems), which differently from ordinary language use internal rigour and formalism (Turchi & Dalla Torre, 2007).

Moreover, the first part of the term used to name a certain discipline, can track three different types of study objects. The first type regards the objects of knowledge referring to entities with a factual and empirical epistemic status. We are talking about study objects which can be detected empirically (through the senses), that are part of “the world of concrete objects” and, therefore, that find correspondence on a perceptive level, to which it’s possible to refer with an indication, a denotative gesture, that recalls something belonging a “physical world” (perceptible with senses, as we have already said). Such as the anatomical-functional unit (commonly known as “body”): the object of study and intervention of the medical model. The peculiarity of this type of research object is that they are directly detectable and measurable (some, and not all, through appropriate measurement theories), and can be translated on a formal language level, in which these entities are related one another through the notion of cause.

The second type comprises study objects that respond to the same epistemic status, but do not have an empirical and factual basis but rather a theoretical one (so much so, we should call them “theoretical units”, or the product of epistemology). Indeed, we are talking about study objects that are the result of a categorical abstraction that does not have a correspondence on a perceptive level. This is the case of chemistry’s (theoretical) unit, the “atom”. The peculiarity of this type is that the theoretical unit exists (only) because of the use of specific formalism (the use of a formal language), through which the theoretical entities (the theoretical units) are related to one another through the notion of interaction.

On the basis of the epistemic status that has been outlined, the two types of study object create the possibility of having a knowledge-status that is usable by the Community (therefore, that can change the ways that common sense uses to speak, providing contents that would not have been possible/usable/available); thus the epistemic status of these products of knowledge is strongly pervasive within common sense.

The third type regards research objects that have the epistemic status of “theoretical constructions”.

We are talking about research objects that, as regards the theoretical entity (theoretical unit), do not have any empirical (perceptive) correspondence. It refers to fields in which it is impossible to refer to terms that correspond to objects of the “physical world” (perceptible, as we said). We are talking about abstract constructions (categorical constructions) that are generated in the use of ordinary language. The peculiarity of this type is the fact that research objects do not “exist on their own” – as opposed to both empirical factual entities, linked to perception, and theoretical units generated within the formalism of the language they refer to – but are entirely built in the knowing categories used in ordinary language; to put it better, it is strictly connected to the use of ordinary language (*logos*), without which the construction would not be generated (defined, as we said, as a theoretical construction). The only possible relationship between theoretical constructions refers to the notion of interaction, such as theoretical units (not the cause one) (Salvini, 1998). Considering the described epistemic status, after the product/birth of knowledge, this type of study object does not translate into a knowledge-status that can be used by the Community and so the possibility/usability/availability of theoretical constructions in the change of common sense’s statements is poor. We are talking about a very critical passage which the two study objects illustrated before do not have to face; in fact belonging to *logos*, ordinary language, the proposed contents – theoretical construct - are easily confused with and within the vocabulary used in statements of common sense; therefore, they are

poorly pervasive towards common sense, but pervasive enough to allow for two different possibilities, two distinct scenarios (even if they probably interact). The first case scenario, but not first in chronological order, means that these contents (theoretical construct), are so “close” to the vocabulary of common sense that they are completely absorbed by the idiom of ordinary language and, therefore, do not assume any pervasive power over the first. The second case scenario, but not second in chronological order, means that theoretical constructs are absorbed by one of the two previous types of research object (in particular by the first, that is the one that has a connection, a link, is anchored to perception). Given its phylogenesis, the true “risk” of (clinical) psychology, as we will see in the next paragraph, is to remain/be constantly absorbed/unsolved to knowledge coming from an “-ic” suffix and therefore, in operational terms, to/from the health care system, that is the medical/psychiatric field.

Psycho-logos (ψυχή - λόγος) klinikòs (ψλινιψα): etymology and phylogenesis of terms. For a placement of the discipline within the hive of scientific sense (science).

Reference to the etymology and the epistemological analysis offered above leads one to observe how the term used to name the discipline (clinical psycho-logy) is composed of a first part that makes reference to the object of research (psycho-) and of a second part that indicates the knowledge system that can be used to generate the research object itself (-logos). An investigation on the one hand of the research object and on the other of the knowledge system that a science can use allows us to investigate where its foundation lies; hence, in this case, if the discipline is affiliated within *-logos* in the scientific sense, this entails that the knowledge system refers to the use of ordinary language and that its research object is a theoretical construct. Indeed, the term “psycho”, does not respond to the epistemic status of an empirical and factual entity because it cannot be empirically detected (through the senses) and so it does not belong to what has been called above “the world of concrete objects” and consequently it does not find correspondence on a perceptive level. At the same time, “psycho” is not referable to the epistemic status of a theoretical entity (theoretical unit), because on the one hand it is not outlined by the use of a formal language and on the other it exists apart from the use of the formal language itself. Therefore, since the research object “psycho” is linked to an abstract construct generated by the use of ordinary language and does not correspond to an empirical and perceptive level, it is coherent with the epistemic status of a “theoretical construct”. Thus, without the use of ordinary language, the object of knowledge cannot be researched, cannot be investigated: this means that, without the use of logos, it is not possible to know psyche. Here is how, referring to the foundation of science as a *gnosis* (and not as a *scio*), we cannot “achieve a knowing-status” about psyche but, nevertheless, “we can pursue a knowing-process” about it, and, starting from the knowing-process itself, it is possible to advance operative proposals to answer what are known as distress calls (which, moreover, are formulated in logos), in the psycho-logos field. Hence, we are talking about a research object that has the peculiarity of being the product of discursive productions, culturally characterized and historically situated. Here is how, if on the one hand research objects that belong to the epistemic status of (factual or theoretical) entities necessarily have to be based on the adoption of a formalism, constructs necessarily refer to ordinary language’s discursive productions that generate them. In the first case, objects of study do not change because they are only built on the specific use of a formalism. In the second case, objects change every time they are built (used) in discursive productions. Therefore the term “psycho” (read psyche), for example, can mean “mind”, “behaviour” or “cognitive processes” or something else, according to the particular theoretical or rhetorical construct (founded on ordinary language use, namely the use of logos) that is used to know it. Moreover, building the object of knowledge “psyche”, while proceeding to know nothing about it, does not guarantee a unique and sharable operative model because the construct gains value on the basis of the theoretical reference used (to generate it). This further aspect of the epistemic status of the “psyche” construct, has entailed that, in operative terms, two different structures can be (could be) outlined: a) every theoretical reference can produce (has produced) its own application model (and not its operative model) (see the proliferation of application models in the field of psychotherapy, for example); b) using the medical model as a reference (see below) to have an “operative knowing-status” derived from another epistemic status (the first type of study object described in the

paragraph). However this entails the complete distortion of the value of a construct and the blend (or the total fusion, as described before) of the knowledge specificity.

Now, in order to connote the specificity of the term *psycho-logos*, combined with the word “clinical” (which etymologically means “that is done next to the bed”, dictated by “the practical medical observation”), used within the discipline, consider the phylogenetic elements that recount the genesis of the discipline itself. Therefore, the recourse – of the argumentation - is to a brief and general historical excursus about the birth of (clinical) psychology (Turchi & Perno, 2004).

The historical moment in which (clinical) psychology was born is the 17th and 18th century, a period during which the operational medical model revealed its operational power, “winning” the challenge for efficacy on the body against the operational shamanic model (in use until then). As a matter of fact, the medical model began to “win” a duel that was historical as well as methodological and operational. This historical period saw the rise of the first places, locations, buildings, in which bodies were taken away from the places they lived in, taken in and “put away”: the first hospitals were built (in Greek *νοσο*, which means “illness” and *ψομιο* that means “cure”; i.e. “*where ill people are gathered and cured*”). Indeed, around the middle of the 18th century, in the United States and in Europe large buildings were built to ensure the confinement of the anatomical and functional units (“the body”, as we said). Those who we today call “doctors” offered a clinical and operational contribution to what for the first time in history was seen – and at the same time observed – as a “body”; a body that had its own organization (differently from what was believed within the shamanic model, namely the every physical part of an individual is related to something else, for example something external to it, that could be spiritual or earthly, that influences and/or conditions it; see Atkinson & Hilgard, 2011). It was to make the knowing-status of body knowledge more effective that people were taken away from their social environment and placed in these buildings (not detention centres for violation of the law). This change in the way in which people's bodies were managed arose, in phylogenetic terms, from a precise and anything but chance watershed that arose in response to major scourges such as epidemics which threatened the Community. In fact, until then, people had been treated in their homes but because of the great scourges like the plague that struck humanity between 1500 and 1600, the medical model – which was becoming more clearly outlined and more precisely defined scientifically by the day – considered what was needed to enhance its own therapeutic efficacy through intervention other than that in the home. This is how direct empirical observation (perception), performed in appropriate locations (which were built to meet operational requirements rather than requirements of hospitality), provided the medical model with the chance to assert that infection was reduced by the isolation of those afflicted by the scourge in facilities such as hospitals. The process of knowledge generated a knowing-state that did not exist within the shamanic model, whereby doctors operate in order to reduce the uncertainty of medical cases during major epidemics (which apart from the Plague, was also typical during epidemics such as leprosy and cholera). History tells us that the last major epidemic of the Plague was celebrated with the construction of La Salute, the church dedicated to the Virgin of Health in Venice where, in 1630, more than half a century after the dreadful pestilence of 1575-77, the disease had once again struck the city of Venice. The governor of the city, the Doge, made a solemn oath to build a church called Salute, meaning Health, in order to beg the intercession of the Virgin Mary to end the pestilence. This marked a major turning point and the birth of hospitals.

The creation of hospitals, beyond having a certain historical relevance, is also important for scientific knowledge. Indeed, what happened was that doctors also started “putting away” those who had not contracted any contagious disease, meaning even cases that did not have an organic pathology. So, hospitals were also used for those that, for example, did not behave as the social custom of the time required. Therefore, medical intervention was performed, expressed despite the lack of knowledge, on the base of a knowing-status coming from another knowing-process (that concerning the body): it literally authorized itself to restrain and, equally importantly, operate on the patient, because it was useful to satisfy specific demands of the Community.

It was Pinel (Jonquières, April 20, 1745 – Paris, October 25, 1826), doctor and manager of the *Hopital de Paris*, who wondered how to justify hospitalization and the use of a range of interventions coming from the knowing-process of the body in those cases in which it was impossible to find – for the knowledge of the time – an organic illness. He also wondered to what knowing-process to refer these

justifications, since that which was available at the time considered only what was (is) anatomically perceptible, such as the functionalities of the components of the body of a patient. Since he could not find the organic (that is, anatomical and functional) foundation regarding the knowledge he had available, Pinel reached an accomplishment that, to this day, seems fundamental for the fate of (clinical) psychology: he changed the word (from the vocabulary) *psyche*, that up to that moment had been used only within philosophic treatises and historical-poetic literature, and inserted it in the medical/sanitary operations (thus, he used a term that up until then belonged to a lexical level). In the presence of an organic platform (that was becoming every day more precise), he hypothesised the existence of a psychic platform (that is purely hypothetical), **as if** it had clearly perceptible characteristics. What he did, completely unfounded in knowledge terms, becomes possible thanks to the knowing-status deriving from the knowing-process on the body (see above). Thus, Pinel defined the first typically psychological construct, released from an organic platform (and so denotative because perceptible through the senses): *le continent psychique* (Turchi & Maiuro, 2007). This is the historical moment in which (clinical) psychology was born (in terms of genesis) to support the medical model, to justify/authorize interventions that, having no legitimacy to intervene on the “organic platform”, do so on the hypothesized “psychic platform”, and here find their legitimacy in their use, even if they are interventions with medical/sanitary characteristics. This marked the birth of a discipline offering legitimacy to medical/sanitary interventions, linked (in its genesis) to them as a support, responding to precise operative demands. The rising (clinical) psychology offers assistance, and therefore not legitimacy, to an activity that otherwise would not have a knowledge foundation, because *psyche*’s knowledge (as a theoretical construct), is generated in that precise historical instant (the *kairòs* of knowledge), and the medical/sanitary interventions could not have justified themselves on the basis of available knowledge.

Today we could say that the research object “*psyche*”, which is epistemologically a theoretical construct (and therefore purely observational data), is (has been) had a knowing-status conferred on it that cannot belong to its epistemic status. Namely, a knowing-status generated by scientific knowing-processes that study and know factual and empirical data. The consequence is that *psyche* becomes in fact (and also therefore in statements) and not in knowledge, a “perceptive” datum, within the context of a knowledge that is (also) founded on factual and empirical data (which can be perceived through the senses). This “conferral” has had and continues to have repercussions, and not only in operative terms (seeing as the medical model, which is fully “operative” in the health care field, is merely “applicative” in the field of psychology; see below); as a matter of fact, from this moment on (and to this day), this theoretical construct, will be (is) known and so treated, *as if* it belonged to an empirical and factual epistemic status (detectable through the senses) and linked to a medical/sanitary knowing-status. We continued to know nothing about the *psyche*, and yet this triggered a complicated sum of operational procedures, still popular today. In these procedures, *psyche*, through a purely rhetorical transition from a knowledge-process hypothesis, as Pinel described it, becomes a knowing-status as if it is a “thing”, a given fact, certain and exterior (independent) to that process of knowledge that, only and exclusively, can generate it (as a theoretical construct). This transition creates relations and interconnections between (clinical) psychology and the medical model, and is relevant not only within the historical context described, but is also relevant today and causes it to acquire, and alas, to this day, retain, operative, methodological and research implications which are utterly alien to its epistemic status.

The medical operative model: what operations on the anatomical functional unit?

In the previous paragraph we highlighted how the medical operative model built not only the historical but also the application scenario in which clinical psychology was generated as a discipline that intervened on the “psychic continent”. Now, it is necessary to embrace a further argumentative and founding passage. “Medical model” does not stand for “medicine”; as a matter of fact, medicine is not referable to the epistemological remarks considered above; medicine is not a knowledge system that generates knowledge, but it is made up of a group of procedures, or better a group of applications of a knowing (a knowing-status) that was generated from a group of sciences (like physics, chemistry, biology, physiology, histology, etc., to produce knowledge it has to remain *-ica*, *-nomos*, *-logos*:

medicine is not one of these forms of knowledge). Here is how the healthcare operator (who is also, but not only, the medical operator, remains an operator that follows an operative model, the “medical” one as we said) is not a producer of knowledge, but a user of the knowledge generated thanks to the three suffixes; he is “health care” because he uses operative procedures (a knowing-status) founded on knowledge assumptions that are available thanks to a set of specific sciences, that produce a specific research object and that generate a particular observational data (empirically detectable, and perceptible through the senses): the anatomical and functional unit (of which now, and only now, thanks to the knowledge that has been produced over the course of time, we can say that we know much but not everything. As a matter of fact, in healthcare/medical terms many aspects which we will not deal with here still need to be defined and described).

Now that we “know”, let us proceed. The operational and medical model, being the expression of a precise knowledge framework, founded upon and therefore coherent with the epistemic status of the research object, is based on three elements. These make up the underlying structure to which the model itself is anchored and are composed of: theoretical assumptions, a goal and a knowledge criterion that authorizes the intervention (these three basic elements also characterize other operational models, for example that of engineering).

The theoretical assumption of the medical model is the aforementioned anatomical and functional unit (called “body” within common sense), certainly defined in theoretical terms (through the use of categorial abstractions that allow us to consider it as observational data), but it is (also) linked to perception: it is defined as an entity, in terms of anatomical unit and functionality between the different components of the anatomical unit itself (for example organs). It is thanks to this assumption that we (can) define all components of the anatomical unit and also how the different components interact. The second element that constitutes the medical model is the goal. The medical model’s goal is healing, thus it is authorized to intervene when it comes to re-establishing the anatomical unit which has been interrupted, modified, altered; and/or, when the functionality between the different components of the anatomical unit has been interrupted, or made dysfunctional (so, to sum up, if a physical external power breaks a thighbone, the broken bone interrupts the anatomical unit; if the consumption of muriatic acid interrupts the functionality of some organs, it changes the functionality of and between the organs that make up the anatomical unit). The third element of the medical model is the criterion that “authorizes” the intervention. We have seen how the research object is collocated in an epistemic status of empirical and factual entity (perceptible through the senses), this entails that the relation between elements is causal, therefore the criterion of the medical model searches for the causes of the pathology. Hence, it is the intervention of casual *noxa* that changes the anatomical unit and changes the functionality of the components that make up the anatomical unit; and it is the fulfillment of this criterion that authorizes the operational model to intervene; moreover, only in presence of the fulfillment of this criterion it is possible to pursue the goal of the medical model: healing.

On the basis of these fundamental elements – which, apart from some valuable exceptions (Fiara, Predabissi & Salvini, 1998; Salvini, 1998) were not examined epistemically throughout history, within (clinical) psychology, although they were implicit and not defined – the medical method can, even now, constantly offer its support to the survival of our species (e.g. in the elimination of major epidemics such as those mentioned above). Moreover, over time, the operational medical model was characterized by the definition/finalization/adoption of a group of procedures: actions that were coherent and congruent with the three elements illustrated above. It is now necessary to proceed with the argumentation and to further describe relations and connections between the medical model and clinical psychology, and we can therefore consider some of the procedures mentioned: diagnosis, therapy and, last but not least, efficacy evaluation of the clinical intervention.

Diagnosis (a word that derives from ancient greek διάγνωσις, formed by διά “through” and γινώσκειν “to know”, “to know through”) is the main procedure of the operation of the medical model. As a matter of fact it is the procedure used – helped by knowledge tools to which it can refer (such as those clinical exams that follow gathering information during the interview with the patient) – to trace the manifestation of a certain clinical case back to a specific clinical picture. The rigorous and precise correspondence between this procedure and the epistemic status of the research object (the anatomical and functional unit), allows us to subdivide the diagnosis procedure into two main types: diagnosis with certain cause and diagnosis with uncertain cause. In the first case, the criteria of the medical

model is fully satisfied, so casual *noxa* is checked with certainty, and the diagnosis manages to use the diagnostic label for the clinical picture at hand (for example: pneumonia); in the second case, the criterion is (only) supposedly satisfied, so the manifestation of casual *noxa* is not certain but presumed, because only the alteration of the anatomical unit and its functionality is certain (meaning detectable as a denotation), but what has caused it is not (we are referring here to the first type of research objects). In this case, the medical model, since it is unable to use a diagnostic label, gives a description of the clinical picture and so determines its syndromic status based on some descriptive elements (usually with reference to the components and their functionality in the anatomical and functional unit involved; for example: A.I.D.S, Acquired Immuno Deficiency Syndrome).

Another absolutely central procedure for the medical model is therapy (which follows diagnosis in a flow chart) and, with the specifications that follow, the treatment. Based on a clinical picture with a certain cause, the health operator, who pursues the goal of healing the anatomical and functional unit, can prescribe a therapy aimed at the re-establishment of the condition of the anatomical and functional unit as it was before the intervention of the casual *noxa*. When a clinical picture has uncertain cause, it becomes evident that the operative method is unable to pursue the goal of healing (because it can not act on the causes, which are still presumed); so therapy (from greek *θεραπεία*), from a healing procedure, becomes subordinate to the general strategy of treatment (because it acts on the effects of the cause and not on the cause itself). As we will see below, this is one of the most critical operative passages in the psycho-logos field.

Another procedure which has to be considered, since its outcome in the health care field is the victory of the medical model in a historical challenge against the shamanic model (but as we said, not only), is the one called efficacy evaluation of the intervention; generally speaking, this procedure concerns the use of a protocol which, being universally recognised, makes it possible to evaluate the efficacy of interventions: we are talking about randomized and double-blind clinical test (which in prospective terms aim to generally evaluate the effective actions of a therapy, even if it is mostly used to evaluate the therapeutic efficacy of a medicine's active ingredient). One of the peculiarities of this evaluation protocol is that neither patients nor health care operators know the nature of the therapy being administered.

The operative medical model: what are the applications for psyche?

The genesis of clinical psychology within the operative context of the medical model and the absence due to the lack of an epistemic analysis of a distance between this and an operative psychological model *strictu sensu*, has led to the adoption of the former within the field of the psyche construct, producing a contamination, in some cases an absorption, of the latter by the former. An operative model genuinely referring to the construct of the psyche, since it does not have any scientific legitimization, becomes – as we have said until now – seriously compromised, or in any case easily contaminated by statements of common sense. The theoretical assumptions of clinical psychology cannot be the anatomical and functional unit for three different reasons: firstly because otherwise there would not be any need for a psycho-logos knowledge field included in the medical one (on the other hand, we have seen how historically clinical psychology arose from an operative request of the medical model); secondly, because this theoretical assumption does not respect knowledge dictates imposed by the type of research object, namely psyche as a theoretical construct; thirdly, since we can only apply the concept of interaction and not of cause to a theoretical construct, (for example) we proceed from present to future and not from present to past. This entails that an operative psycho-logos model cannot have healing as its goal, by which we mean the re-establishment of the anatomical unit that has been interrupted or the functionalities between the different components of the anatomical unit, because it has neither an anatomical unit nor its functionalities (the theoretical construct cannot be perceived); whereas, on the basis of the theoretical construct we refer to, it is possible to intervene on interaction, with the person or institution and their distress call (and not eliminating or reducing the intervention on cause). Therefore, since the psycho-logos research object has the epistemic status of a theoretical construct, and not of an empirical-factual entity, its criterion can not be referred to pathological cause, but rather to dialogue, thus managed by interaction between those discursive productions that generate it (in particular the used theory).

So, on the basis of what has been described above, even though the medical model cannot be a reference for clinical psychology, it would nonetheless still appear to characterize interventions in the psycho-logos field. In other words, despite the fact that foundation elements show that psychology, in the clinical sense (too), has a research object with a different epistemic status to that of the medical model, we have highlighted how it has paid, and still pays, a heavy toll to the field in which it originated and from which it has inherited much in terms of both science and application. Therefore, since it proves impossible to apply the medical model in the psycho-logos field, as in the health care field, what occurs is a repeated and spurious application of this, with hybridizations that are unfounded on the epistemic status of the research object of the theoretical construct (psyche). Thus, we proceed as if we had a knowing-status, when instead we keep generating knowledge-processes, on the basis of the construct we are referring to (that is the theoretical adoption), generating continuous interactions with (thanks to) it. Moreover, this status of epistemic incorrectness has repercussions on the efficacy of the operations thanks to and from the discipline, with no possibility of evaluating the adequacy and pertinence of answers to the requests that come from the Community (the “distress call” we talked about at the beginning of this contribution).

As a matter of fact, the argumentation has pointed out that, if we consider the diagnostic procedure as the key moment that allocates a clinical case to a certain diagnostic picture, the medical model highlights two possible scenarios depending on the certainty or supposition of the cause. In the psycho-logos field, since there is no intervention on a cause (because the research object has the epistemic status of theoretical construct), clinical pictures should be traced back, at the very least, to a diagnosis with uncertain cause; therefore, in operational terms, it would be impossible to use the diagnostic label referred to a certain clinical picture anyway, but, at the most, we would find ourselves describing a syndromic clinical picture. Moreover, again in terms of application of the medical model, we (also) detect a methodological error in the term “mental illness”: at most we could be said to be dealing with clinical pictures that are not illnesses but “mental syndromes”. And, again coherently with the medical model, given that these clinical pictures have an uncertain cause, the therapeutic procedure ceases to be the main one (since the cure becomes central). To put it better, since we have no cause, we cannot use procedures (such as pharmacological therapy) that operate on the re-establishment of the anatomical and functional unit before the intervention of the *causal noxa*. In fact, based on the research object’s epistemic status, no knowing-status can be used for the psyche and therefore no medical method application can be produced, whether we are talking about diagnosis or therapy. Therefore a (clinical) psycho-logos operative model cannot operate in the health care field but rather in the social health field, where there is a dialogical criterion and therefore we interact, through a theoretical construct, with the social health construction of “who asks for help” (whether if it is an individual or an institution). The evaluation of efficacy procedure of interventions is (also) not applicable, because the protocol used by the medical model, the “double-blind” one, if used in the psycho-logos field would highlight the in-efficacy of interventions because they are not coherent with the epistemic status of the research object. (Turchi & Perno, 2004).

In the light of this knowledge hybridization (epistemologically unfounded and methodologically incorrect) between the medical model and “psychological model”, we need to ask what its pragmatic effects are. What is the contribution that this hybrid model can offer to what we refer to as distress calls whether old or new? Where is the scientific responsibility, besides the civic one, of all psycho-logos operators? All these questions have yet to be asked and therefore fail to generate knowledge processes that give answers and open the way for to new operative proposals that differ from that offered by clinical psychology (with a certain dissatisfaction of the civil Community).

From medicine to psychiatry: from the empirical entity to the “entity-zation” of logos.

The historical period during which clinical psychology first came into being is characterized by the maximum application of mechanistic paradigms, that were still far (in terms of knowledge shift) from what would have happened about a century later with the rise of relativistic paradigms (thanks to Einstein’s theory of relativity) and, above all, with the rise of interactionist paradigms and Heisenberg’s uncertainty principle. Even if it is a repercussion, it is within this context that we must consider the “psychic continent” coined by Pinel, a categorical abstraction arising from the precise

requirements of the medical model; it is equated with - and therefore considered - as a cause that, within the mechanistic paradigms, substantiates the way of knowledge. Therefore, on the basis of “psychic continents” stated as different (because the psychological theories that follow one another are different), within an epistemic slip they are considered possible causes of non-organic nature. In fact, this is the one rhetorical (not knowledge) operation that manages to authorize the medical/health care operation and, as described above, the recourse to, hospitals, for example, when on the other hand we are faced with a research object that is a theoretical unit.

Another historical development to be considered in the effort to define an operative model that can be applied specifically to psycho-logos, is, firstly, the birth of psychopathology and, secondly, that of psychiatry. As regards the definition of an epistemic status of the research object, we have highlighted how, within the psycho-logos field, the application of an operative model is neither complete nor rigorous, but rather, spurious, therefore without the support of a knowledge structure to guarantee its efficacy (at least as a procedure). Consequently, on the base of psychology’s application of the medical model, the denotation of clinical pictures with uncertain cause (therefore syndromic ones), has promoted the birth of the (first) taxonomies in the psychological field. Following the formulation of the “psychic continent”, psychopathology was born and the first psychological taxonomies started to be used. Psychopathology developed mainly in Europe, in particular in Germany, and between the end of the 19th century and the beginning of the 20th century, for reasons that will not be dealt with here, was replaced by a new discipline: psychiatry. As early as the the end of the 19th century, Freud coined the first psycho-logos theory, that had no reference to the anatomical and functional unit (even if an aspect that the exegetes at times fail to remember is that he himself starts by highlighting that his theoretical proposal is so while waiting for the definition of the nerve cell; we should remember that Freud had a medical and neurological education); the first Freudian topic (also) saw the rise of the first classification of the psycho-logos field: the clinical pictures were divided into *neurotic* clinical pictures and *hysterical* clinical pictures, based on different discursive productions that characterize them.

On the basis of what was produced from psychopathology in terms of knowledge, during the early years of the 20th century the term “psychiatry” would prevail and slowly supplant the term “psychopathology”, since the latter is necessarily linked to all the theorizations in the psychological field. Psychopathological classifications would also be abandoned and replaced with psychiatric classifications which were included in manuals in the field that - to this day - are periodically updated (what is known as the Diagnostic and Statistical Manual of mental disorders, or DSM). Since the early Seventies of the past century, psychiatry has been marked by the use of a “descriptive” model which has been present in the psychiatric field since the mid-19th century. The choice to share a “descriptive” model rather than an etiological one aimed at detecting the mechanisms and generative causes of a supposed “mental disorder”, comes from the scant and contradictory results that “biological psychiatry” obtained in earlier attempts. And it was in fact thanks to this criterion that it was possible to order the clinical material collected during the years it was studied, and this issue gained in importance considering that the first edition of the DSM - dated 1952 - represents today one of the tools that are mostly used within the clinical practice of “operators of the psyche”.

What we are talking about is a manual that currently gathers more than 370 “mental disorders” (DSM-IV-Text Revision - DSM-IV-TR, today in effect since 2000), described on the basis of the predominance of certain “symptoms” - namely discursive productions that would substantiate a description (written on the manual), after the observation of a behavior that the psychiatric knowledge-status considers “pathogenic”. A “clinical picture” set up in the psychiatric field, understood as a constellation of symptoms, is justified by two criteria. The first is that of “return and concomitance”: on the basis of what we have said to now, we can assert that this criterion cannot be respected within the psychiatric procedure because “return” and “concomitance” depend on the theory used by both the operator and the individual who has given the distress signal: both can know the symptomatology through the use of logos. The second criterion is that based on the “causal focus”, which as we have already discussed in detail, cannot be honored within the psychiatric field, because the epistemic status of the construct is theoretical and empirical and factual (linked to perception), therefore we find ourselves in no condition to detect any underlying cause to the supposed “disorder”. Therefore the epistemological “violation” that rotates around the “conceptual fulcrum” of the procedure and the psychiatric diagnostics is the term “mental disorder”. The addition of the adjective “mental” is

supposed to indicate the “anatomical” placement of the “disorder/illness” and this is unfounded because “mind” does not indicate a physical and defined place. In fact, the term “mental disorder” is an expression made up of two terms that are anatomically antinomial: the term “disorder” coherently with the epistemic status of empirical and factual entity pertains to the medical method; whereas the term “mental”, since it is a construct, is a hypothetical reality that can only be known through the categories used to build it as it is (hence within the expression mental disorder we are in the presence of two different types of research object). In DSM-VI we can read that “*every mental disorder is conceptualized as a syndrome or as a behavioral or psychological model which is clinically significant, present in an individual, and associated to a discomfort, disability, significant increase of death, pain or disability risk, or to a particular event, for example the death of a loved one. Whatever the cause is, it has to be considered at the moment the expression of a behavioral, psychological or biological dis-function of the individual*”. We can observe how, to define the medical method’s concept, in the psychiatric field, terms and expression that confuse the research object (its epistemic status) are used, generating an overlap that creates confusion within the psychiatric field, and produces non-scientific definitions, which however appear as (simple) common sense statements.

For example, psychiatry’s descriptive approach considers a “mental disorder” as a syndrome and, during the empirical observations (but there cannot be observation without theory as we have already said), it appears as a set symptoms, gathered with a stochastic and inductive criterion. This is the critical aspect that is generated when psychiatry, with lack of scientific foundation, tries to borrow the medical model. On the basis of what has been considered, we can conclude that within psychiatry the concept of “illness”, called “mental disorder”, does not find its place in the scientific sense’s knowledge process, because it lacks any foundation. In the psychiatric field the clinical picture is justified only by the strength of the argumentation that lies in the use, in purely rhetorical terms, of the metaphor that places the “mind” as the *alter ego* of the biological body (of the anatomical and functional unit). The theoretical representative of the medical method is the anatomical and functional unit (that is linked to perception), and it is the only “place” where diagnostic verifications, falsifications and operational applications are carried out. Psychiatry on the other hand, having the “mind” (of which we do not have a theory and therefore knowledge) as its own theoretical support, appears in any case to be a production of logos (a categorial abstraction), with no link to perception. Therefore the “mind” becomes a powerful rhetorical expedient (and we find ourselves in common sense, where “reality” claims to be as much), the only possibility that psychiatry has to operate under the aegis of the medical method since the disorder does not have an epistemic status in terms of causal *focus* (nor *locus*, as we have already stated). For this reason, note how – for example – a label such as “cerebral disorder” has never been coined. In fact, the use of this label would have given the impression that there was a causal focus of the disorder: the brain. And this has never been the case and never will be.

What operative model can there be for clinical psychology?

Given the founding elements at the origin of the knowledge structure on which the procedures of a (purely) psycho-logos model must lie, the operator’s intervention is distinguished by the adoption of epistemological references which can take on the management of a distress call (whether from a person and an Institution). The reference to the epistemological analysis and the “concept” of science as a *gnosis* makes it possible to identify three assumptions that offer substance to the proposal that we intend to put forward. The theoretical assumption of the operative model is that, in line with the purely process-oriented epistemic nature of the research object, the discursive productions used by the interlocutors/speakers generate reality (that is, they configure it as it is). Therefore the reality that constitutes the research object is not the body but how those who use the language construct reality and therefore (also) how they speak about the body itself (within the use of logos or ordinary language). Hence what is examined, and is relevant in order to have a model that can intervene “always and no matter what” in the purely psycho-logos field, is the discursive productions, namely how, through the use of logos, interlocutors/speakers configure reality. This operation not only fulfills the criterion of pertinence to the epistemic status of the research object but at the same time makes it possible to escape from the morass of “hypothesis about psyche” that has historically invalidated the

generative offer of interventions and the lack of a shared method among operators in the field. It is only by ceasing to refer to the “hypothesis about psyche” that gives the operators the chance to intervene in what, at the beginning, we described as “new challenges”. As a matter of fact, what has happened and continues to happen is that what is said about psyche in terms of *logos* is relegated – by means of a purely rhetorical operation – within the body (the anatomical and functional unit). But how can we relegate to the body issues that regard the interactions between different cultural systems of a Community, social changes within it and the so-called “external causes”? The proposal of a model that operates on *logos* – and therefore on the ways of constructing reality which are used by people to create it – enhances the generative potential of an intervention, since it is rooted in the definition of the research object, which as we said becomes *logos*, and that is purely process-oriented (we are in fact dealing here with the theoretical unit type of research object). This becomes the principle that allows the operator to intervene and (also) do so with regard to the “new challenges”. Therefore the intervention is on the ways, that is the discursive productions, that are used to configure reality as an “illness” and not as health. Therefore, the criterion cannot refer to the pathological cause because it cannot be coherent with the research object and consequently, the goal of the operative model cannot be that of healing, but rather that of changing the discursive configuration. The principle – which brings us back to a fundamental historical moment for scientific sense such as the arrival of interactionist paradigms and the formulation of Heisenberg’s uncertainty principle – relates to the observation that the discursive configuration of reality, being uncertain and thus constantly changing, can thus be changed at any moment no matter what it is.

This is how the remarks made above allow us to assert that the use of an operative model such as the medical one, has forced and continues to force an intervention based on the notion of cause and addressed to the “person”, an intervention that re-establishes a certain anatomical and functional condition. Moreover, the use of the knowledge category of “therapy” within the field of the research object “psyche” constitutes a limitation because it dictates some conditions that the operator must respect which are not legitimized by the epistemic status of psyche. It therefore proves necessary to engage in procedures that dictate conditions of action so that they are coherent with the knowledge structure and also responsive to the efficacy and efficiency criteria in the management of the intervention itself. Thus the proposal is to give rise to an operative model where the psycho-*logos* expert, reflecting on knowledge and its generation as *gnosis*, creates a shift in a way of knowing founded on interactionist paradigms and embraces uncertainty as its own. The operative model proposed here places *logos* as its research object, that is the knowledge structure itself – i.e. the instrument – that is (itself) employed by those who use it to generate and “talk about psyche” (“clinicians”, the experts), and by those that configure their own “psychological reality” (interlocutors/speakers, the ingenuous). This exposes the difference between this purely psycho-*logos* operative model and an operative model (such as the medical one) that places an empirical and factual entity (namely, the body) as its research object. The operator (or expert) acts as an “architect and engineer” of discursive productions; in fact, starting from *logos* and using *logos* itself as an operative instrument, he can generate other discursive productions that are different from that used to request the intervention: this way he becomes operator and promoter of change (of the discursive configuration). On the basis of these fundamental elements for the proposed operative model (which we call “dialogical”), we describe below the procedures that characterize its application in the clinical field (see Tab. 1).

The first procedure is *sinesis*, that is the gathering of *logos* that describes the configuration on which we will intervene. What is needed is the collection of the discursive configuration and therefore, through the use of appropriate questions, making available the discursive productions that are used – for example – by the client, family members, or the expert. Let us consider, as an example, the case in which a client says: “*I fell into depression when I lost my job. I was fired and from that moment on I started to suffer from insomnia and I couldn’t do anything but stay in bed. Now I can’t deal with it any more, I feel like dying, and I’m asking for your help*”. On the basis of what the client is saying, the procedure of *sinesis* makes it possible to “enter the merits of” the elements that characterize the client’s request. Which explains the use of questions in order to “explode” all the elements already present in the request, so the discursive configuration becomes available, we have a clear picture and are able to suggest some intervention strategies.

Subsequently, the operator introduces the procedure of *scepsis*, that is the observation of the discursive configuration, which allows the operator to define the intervention strategies. Beginning with the discursive productions that are collected by the questions, the clinical observation of these implies identification of the ways that distinguish discursive configuration as well as the content elements that characterize it (always with reference to the client). Since we do not have an empirical and factual entity and therefore cannot predict developments, an operative procedure that is available to the operator of change is the *anticipation* of future discursive scenarios that may or may not occur, arising from the discursive configuration examined. Therefore, using the example considered above, what an operator anticipates are future scenarios, namely the discursive configuration arrangements that can be generated out of what the client is configuring and which must be considered during the intervention. Thus, it is about the condition of health (of a person or of a community) that changes and is in constant transformation, rather than to a health care status that remains linked to the medical model.

The other procedure is *dieghesigenia*, that is the triggering, the generation of an “other” discursive configuration from that which is available at the moment of the intervention, and this happens thanks to the operator’s use of certain strategies. This procedure allows the operator to generate the use of other ways and other elements that can propose another discursive configuration of reality. Namely, with this procedure, the operator uses rhetorical and argumentative ploys and stratagems that aim at changing the discursive production that the client, on the other hand, states and declares to be the only one, not imagining that there be any possibility for change. Last but not least, coherently with the theoretical assumption on which the dialogical model lies, it is possible to field an efficacy evaluation of the intervention; in fact on the basis of the difference between the discursive configuration generated and that at the beginning of the intervention. Hence the operator has a questionnaire that, using the same question at the beginning and end of the intervention, makes it possible to detect the differences and certify the efficacy of the intervention itself. This instrument appears important not only for the certification of the efficacy itself but also for its use in the monitoring phase, therefore in order to offer a support and help to the operator during the intervention so that he can avail of some indications that allow him to act in a way that is efficient for achieving the goal. Finally, the operative model makes a procedure which definitely frees the field from references to the notion of cause; that is, it allows for the *promotion* rather than prevention of certain discursive configurations (such as that of anticipation of certain illness scenarios or common sense theories about the client’s illness).

Conclusions: for a “new” clinical psychology

The argumentation that has characterized this work departed from a remark about how today, more than in the past, (clinical) psychology is going through a phase during which demands have changed and, consequently, all those challenges that the discipline has to face must be seen as part of a precise set of historical and cultural circumstances. In confirmation of this, if we consider how nowadays, the spheres of intervention increasingly involve requests from clinical psychology, we can see how we are facing demands which increasingly concern not just the biography of individual people but that of the Community as a whole. In fact, these “new” demands appear increasingly linked to globalization and world economic crisis which together are generating precarity and insecurity in various aspects of people’s lives (such as work, family, and the “new poverty”, etc.). This has such serious repercussions on people’s lives that it could compromise the survival of our species. Consequently, the fields in which clinical psychology is called to intervene today are increasingly subject to the uncertainty of events and their development. All this is undermining “life’s principles” and entails continuous strain, with consequent worry, on structures and models that up to now have operated on “social support”, which (let alone today) are not able to provide adequate answers to demands for intervention.

And this is why this contribution aims to answer the internal need of the discipline itself: to think up an operative model for clinical psychology which, freed from the overlap with the health care field, can be an expression of scientific sense. The use of the latter has a strategic value to help clinical psychology manage uncertainty and transform it in a constant occasion to finally promote social health (within which physical health can be found) of individuals and communities. Therefore this contribution’s argumentative path has unravelled issues about the foundation of knowledge, and thus the epistemology of scientific sense. This passage has made it possible to use three knowledge tools

(etymology of terms, philology, and epistemic analysis) which allowed us to precisely define:

1. the field of application of (clinical) psychology;
2. its peculiarities (in terms of epistemic status of its research object)
3. the discipline's own ways of knowledge.

The application of this passage has effects of two kinds.

The first is the definition of a clear-cut distinction between a social health level (clinical psychology's knowledge and research object) and a physical health level (the medical model's knowledge and research object); on the contrary, historically, they have been the objects of a conceptual error: the overlap and connection of the two levels. This has had tragic repercussions that (even) today we (wrongly) continue to relegate clinical psychology to the medical model's approach. The second, which is a consequence of the first, is that the fundamental manoeuvre of anchoring clinical psychology to science can guarantee the definition of operative procedures that are the expression of a psychological model in the strictest sense. This operation, differs from the medical model's procedures in that it aims to offer assistance – for issues that are connected with but not pertinent to the medical model – to aid the efforts that have been made to win the “new” challenges linked to the survival of our species and which today are not merely about physical health.

In conclusion, in *Table 1* below, we report on the antinomian correspondences between the medical model's procedures and those of the dialogical model which that have been proposed in this contribution whose object is logos and which presents itself as a proposal in the clinical-psychological field. The proposal, formalized in the table below, freed from a strictly body-connected level of intervention, is based on the assumption that reality is constructed in a discursive manner (Turchi, 2002), and has the operative effect that any discursive configuration or demand can be embraced. In this way, operators become those who, both for institutional mandates and scientific rigour, can offer support (to the individual as to the Community) not to define “what” has been contracted (by the individual or Community), therefore using the notion of cause, but rather to offer support to the person and/or Community, to intervene in the discursive scenario generating the distress call.

Therefore, the operator's intervention is not characterized by healing goals, but rather by health promotion goals. This passage allows people (and thus the Community) to proceed, also in the long term and in a future perspective, in an autonomous fashion so that they become active agents facing the challenges of this historical moment.

Table 1

MEDICAL MODEL		DIALOGICAL MODEL	
CASE HISTORY	Reminiscence memory	SYNESIS	collection
DIAGNOSIS	look through	SCEPSIS	observation
PROGNOSIS	Prediction	ANTICIPATION	Anticipating, acting ahead of time
TREATMENT	Service, cure, treatment, assistance	DIEGHESIGENIA	Narrative generation, creation
EVALUATION OF EFFECTIVENESS		EVALUATION OF EFFECTIVENESS	
PREVENTION	To look ahead	PROMOTION	Move forward

Bibliography

- AMERICAN PSYCHIATRIC ASSOCIATION (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington (DC): The American Psychiatric Association.
- Atkinson, W. W., & Hilgard, E. R. (2011). *Introduzione alla psicologia*. Padova: Piccin.
- Carli, R., & Paniccia, R. M. (2011). *La cultura dei servizi di salute mentale in Italia. Dai malati psichiatrici alla nuova utenza: l'evoluzione della domanda di aiuto e delle dinamiche di rapporto* [The culture of mental health services in Italy. From mentally patients to new users: help request and relationship dynamics evolution]. Milano: FrancoAngeli.
- Fiora, E., Pedrabissi, L., & Salvini, A. (1988). *Pluralismo teorico e pragmatismo conoscitivo in psicologia della personalità* [Theoretical pluralism and cognitive pragmatism in the field of personality psychology]. Milano: Giuffrè.
- Marhaba, S., (1976). *Antinomie epistemologiche nella psicologia contemporanea* [Epistemological antinomies in the field of contemporary psychology]. Firenze: Giunti Barbera.
- Molinari, E., & Labella A. (Eds.). (2007). *Psicologia Clinica Dialoghi e confronti* [Clinical Psychology: dialogues and exchange of views]. Milano: Springer.
- Salvini, A. (1998). *Psicologia Clinica* [Clinical Psychology]. Padova: UPSEL.
- Salvini, A., & Galieni, N. (2002). *Diversità, Devianze e Terapia*. [Diversity, Deviant behaviours and Therapy]. Padova: UPSEL.
- Turchi, G. P. (Ed.). (2002). *Tossicodipendenza. Generare il cambiamento tra mutamento di paradigma ed effetti pragmatici* [Drug addiction. Generating change between paradigm modification and pragmatic effects]. Padova: UPSEL.
- Turchi, G. P., & Della Torre, C. (Eds.). (2007). *Psicologia della Salute. Dal modello bio-psico-sociale al modello dialogico: generare e gestire processi trasformativi nell'ambito della salute* [Health Psychology – From bio-psycho-social model to dialogic model: generating and handling transformation processes in health field]. Roma: Armando Editore.
- Turchi, G. P., & Maiuro, T. (2007). *La riflessione epistemologica come criterio di scientificità in psicologia clinica* [Epistemological reflection as parameter of scientific nature in Clinical Psychology]. In E. Molinari & Labella, A. (Eds.), *Psicologia Clinica Dialoghi e confronti* [Clinical Psychology: dialogues and exchange of views]. Milano: Springer.