Clinical psychology: profession and research.

by Renzo Carli*

Questo è un nodo avviluppato,
Questo è un gruppo rintrecciato.
Chi sviluppa più inviluppa,
Chi più sgruppa, più raggruppa;

Ed intanto la mia testa
Vola, vola e poi s'arresta;
Vo' tenton per l'aria oscura,
E comincio a delirar.

La Cenerentola or *La virtù in trionfo*
Act II scene eight
Libretto by Jacopo Ferretti – music by Gioacchino Rossini

1. – Preamble

Why should we yet again wonder about what Clinical Psychology is?
In the first issue of this journal (1982), in its printed version, the question was answered by S. J. Korchin, L. Ancona and R. Holt; in the last issue of the same journal (1997) the problem was posed by G. Trentini, A. Imbasciati, G. Guerra and N. Rossi, G. Montesarchio, S. Salvatore and M. Grasso. Today, in the first issue of the on-line form of the Review of Clinical Psychology, it is still being discussed by M. Grasso, A. Imbasciati, Di Blasi with Lo Verso, Cigoli with Margola, Di Maria with Falgares, and by Carli.
In fact in recent years Clinical Psychology has given its name to several Degree Courses and to numerous Schools of Specialization. At the end of the nineties it lost the battle to gain professional recognition, giving way to psychotherapy and to its various schools and courses. It remains, however, an area of psychology that is important and of great interest. Why?
One answer can be found in what Clinical Psychology has initiated and promoted in Europe: the notion that psychology can assume not only the function of studying and describing reality, but also the role of *intervention to change that same reality.* The word "clinical", as G. Guerra recalled in his 1997[1] contribution, refers to the patient lying on the bed, on the one hand, and to the act of bending over someone to respond to his request, on the other. It is this bending over, as an act of intervention, that has been for many years the focus of our attention and our research. This act of bending over and intervening has been cast aside by the human sciences (sociology, economics, anthropology), in favour of the function of knowledge. The possible intervention – within known reality and described with its own categories and models – is reserved to the seats of power where they have become consultants[2]. Clinical Psychology (along with Psychosociology of French matrix) has worked out its own models and methods of intervention, concerning single individuals as well as organizational structures in the most varied domains and sectors of the social system.

2. – Towards a definition of Clinical Psychology as a intervention

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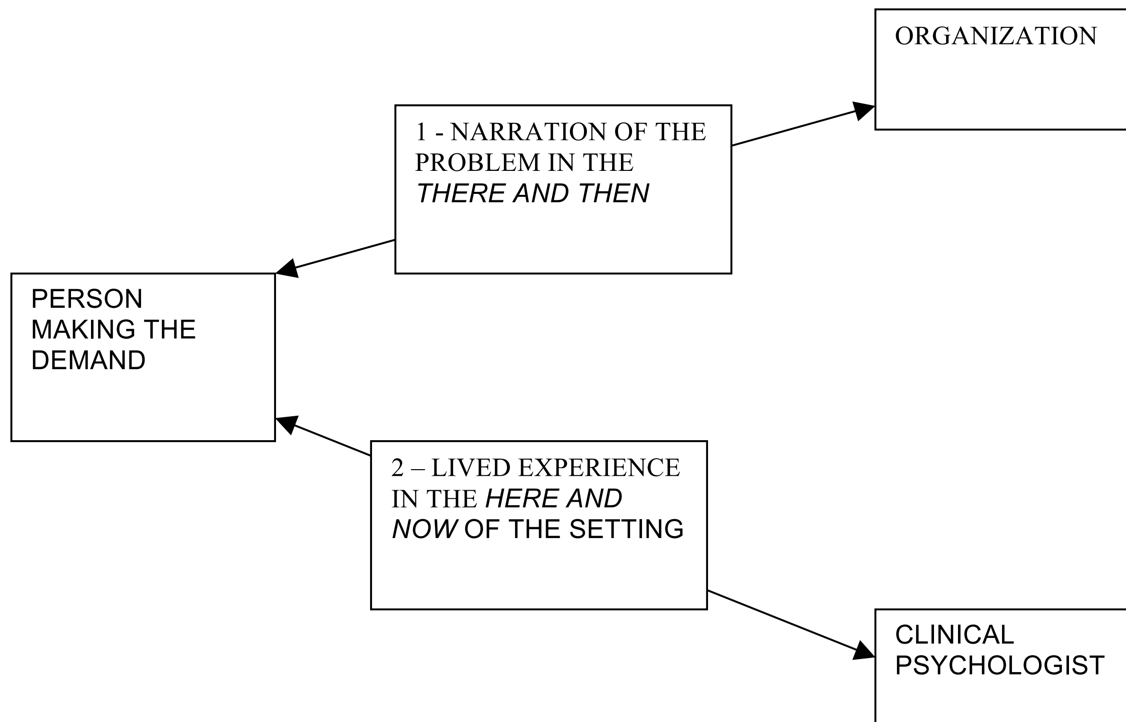
[1] Guerra G. (1997), Psicologia Clinica e Psicologia Generale, *Psicologia Clinica*, 3, 58-66. (Clinical Psychology e Psychology Generale).

In brief, these are the salient features of the Clinical Psychology intervention:

a – the intervention *responds to a demand* addressed to the clinical psychologist on the basis of a problem "experienced" by the person who makes the demand; it is not a response to the diagnosis of some disease or distress made because of the psychologist's mission;
b – the intervention does not have an orthopaedic function (cure for disorder, return to the straight and narrow, return to conform to social rules, correction of the deficit), but rather the function of facilitating an *analysis of the demand* and a *process of knowing the relationship* that is established with the clinical psychologist;
c – the intervention aims to promote the *development* of the system that made the demand, removing the defensive relational dimensions that hinder development;
d - the intervention may be *commissioned* by single individuals, social groups, organizations and institutions;
e - there is no direct relation between the problem underlying the demand to the clinical psychologist and the theory of technique on which the intervention is based. In other words, people or social groups contact the clinical psychologist because s/he exists and can be credited with some kind of function, based on imprecise, stereotyped beliefs connected to fanciful expectations. It is analysis of the demand that enables the demand itself to be elaborated and the intervention to be given a sense, once the understanding of the problem has been reorganized.
f – the intervention is based on the analysis of the relationship between the person posing the problem and the clinical psychologist.
This relationship can be described thus:

[2] Some forms of Psychology also serve as consultants to organizational power, providing information or useful practices for the achievement of the aims of power itself: think for instance of Occupational Psychology or Applied Psychometric.



The person making the demand structures a relationship with two components:

A – the *narrative component*, where the problem is told, as it is experienced in the teller's own vision of things: a young teenager talks about his lack of confidence in love affairs; a mother talks about the problems she encounters in her family relations; a division head talks about the problems of conflict between the various staff members of the division and the patients or patients' families; company employees relate their difficulty in achieving the goals set, due to the overly strict supervision by their bosses; some temporary workers talk about the lack of career prospects and of hope that they find at work.

B – the *experienced component* in the direct relationship between the person making the demand and the clinical psychologist.

It is interesting to see how the split between the two components in the relationship leads to two diametrically opposed ways of carrying out the intervention: one of these focuses on the problem and treats it "cognitively", shifting what happens in the relationship into the background; the other focuses on the relationship and its emotional dynamics, independently of the problem posed, which is seen as a mere pretext for the relationship itself.
We are faced with the two most significant areas of psychotherapy: cognitive psychotherapy on the one hand, psychoanalytic psychotherapy on the other. Admittedly, things have evolved considerably since the beginnings of these forms of psychotherapy, which have grown closer together in a sort of hybridization which tries to take into account both the relationship and the problem cognitively narrated. The fact remains that

the psychotherapeutic aim can be situated in the problem narrated on the one hand, or in the dynamics of the relationship as it is experienced by the patient, on the other.
The clinical psychology intervention looks at the relationship, in the here and now, as the *reproduction* of the problems that are experienced in the there and then by the person making the demand.
The reproduction of problems within the relationship, on the other hand, can only be seen if one uses models and theories concerning the relationship, not just the individual.
This, in my view, is a crucial point in distinguishing the clinical psychology intervention from psychotherapy in the traditional sense.

3. – A clinical example

A fifty-year-old woman goes to the clinical psychologist because she is wiped out by the discovery that her husband has always betrayed her. She has dedicated herself to her husband and three children for thirty years; she has put up with her husband's domination in everything, voluntarily demeaning herself so as to confirm his *grandeur*. She has negated herself for the sake of a happy family and domestic bliss, playing out the classic Parsonian role of the person who provides emotional support, leaving her husband the instrumental role of breadwinner, associated with his highly successful job. And now she discovers that it was all false, that her husband has lead a sort of double life, indulging in affairs and extra-marital relations right from the earliest days of their marriage.
This is in brief the story of the patient. We must add that the woman contacts a clinical psychologist from the psychology service operating in the National Health Service; she does not ask for any specific form of psychotherapy, as she might have if she had gone to a psychoanalyst or a cognitive psychotherapist in private practice. The problem brought by the woman is therefore not a pretext for entering a precise psychotherapy experience, chosen because of the professional she goes to.
If we look at the narration of this woman who, during the first conversation, shows anger and resentment towards the husband that has tricked and humiliated her, we can imagine the necessary change in her cognitive structures, in the representation of herself and of her husband. One could work, for instance, on the woman's self-perception, reconstructing her self-esteem. This task will be facilitated in its clinical direction if it is organized around some diagnosis of the *disorder* that the woman presents with her narration.

If we look at the dynamics of the relationship and go no further, we might think of a process of interpretation of the relationship of transference established with the psychoanalyst; retracing problems that the woman reproduces with the analyst and that she experienced with her husband, in an idealization of the father figure seen as remote and important for her, especially if compared to the emotional role she attributed to her mother, who persecuted her father and the children with her submissiveness and self-pity. We might also make the hypothesis that idealizing her father led the woman to identify with the figure of the controlling victim, attributed to the mother.
Although it is a highly reduced example, in the first case we are in the "there and then" of the narrative; in the second, we are in the "here and now" of the transference relationship.
Let us now try to use a model of the relationship: the model that I have been putting forward for many years under the name of collusion.
Let us consider the way the woman organizes her emotional relationship with the psychologist, when she talks about the *betrayal* by her husband. Let us think about the verb betray *(in Italian language: tradire)*, which etymologically derives from the Latin *trans* (beyond, further on) and *dare* (deliver). Betrayal can be thought of as delivering to an enemy the flag, the fortress, a person or a thing that the one who betrays has sworn or has the natural duty to defend. The term betray, therefore implies a strong condemnation of the act committed. Judah betrays Jesus at the moment when he delivers him to the enemy, since as a disciple he is bound to obedience and loyalty. *Betrayal, therefore, is an event involving a three-way relationship: the one who betrays, the one who is delivered to the enemy, and a third dimension, of bonds enforcing loyalty and vouching for it, which is the thing betrayed.* Betrayal does not concern only the act of delivering a friend to the foe, but above all, the failure to keep a pact that the traitor had signed with a third dimension: for Judah, it is the group of disciples; for one who hands over the flag or a military secret to the enemy, the Homeland; for the footballer who sells a match to his opponents, it is the "sporting spirit" for his team, and so on.

In love relationships, betrayal is often talked about in an incorrect but interesting way from the emotional point of view. The person who feels betrayed actually implicates a third party in a relationship that, being about the couple, is a dual relationship. This third acts as a witness and vouches for the misdeed of betrayal; the misdeed no longer concerns the person betrayed, but the pact sworn before others as to the loyalty of the relationship. The marriage ceremony in front of the priest or civil authorities is a good example of this third dimension which acts as the guarantor of the pact. Now, the woman who talks about being betrayed does not consciously think of the marriage pact, but rather of what a failure she feels for not having been able to defend the relationship with her husband, and therefore implicitly, that pact. In the feeling of being betrayed there is anger at the violation of the pact, but also the crisis of one's own self-esteem, for not having been able to defend the relationship. In the experience of betrayal there is confusion between the couple's relationship (two-way) and the relationship seen as a pact in the eyes of a social system vouching for it (three-way). The collusive dynamic of the woman who goes to the clinical psychologist because she feels betrayed, is aimed at investing the psychologist with the role of the guarantor who can and must resent what has been done to her. It does not seem difficult to understand that the woman is trying to control the psychologist, by giving him the role of the hypothetical guarantor of her betrayed relationship, just as she tried to control her husband with her submissive, docile acceptance of the claims to superiority that the husband inflicted on her daily. The husband probably accepted this control because he was able to free himself through other less binding and less guilt-inducing relations, mainly secret affairs which were so only thanks to the control exercised by the woman. In betrayal the traitor is assumed to carry the guilt. Blaming the traitor seems a sort of emotional compensation for the wrong suffered.

The psychologist is therefore faced with a question: what demand is the woman making?

As we can see, wondering about the dynamics of the demand is different from asking what the woman's problem is, or if you like, what problem the woman *has*. In the latter case, one hypothesises right from the outset of the psychotherapeutic relationship, that the woman is bringing a problem or a disorder, with the resulting hypothesis that the task of the psychotherapist is to solve the patient's problem, or rather her disorder. If one asks oneself about her demand, however, what is important is not the woman's *diagnosis*, but identifying the *emotional characteristics of the relationship* that the woman is offering the psychologist with her demand. The hypothesis can then be made that the woman felt "lonely and abandoned" by her husband and that she was unable to stand this loneliness, resulting from the destructuring of the relations of control and dedication that she had known for so long. She therefore seeks compensation by reorganizing a relation of condemnation of the husband as traitor: provided the psychologist acts as the guarantor of the pact with the sole condition that it can configure the husband's betrayal and his condemnation. As we can see, our hypothesis was based on the analysis of the word "betrayal" and on its use not in a legal or judicial but in a psychological sense. It would be perfectly acceptable if, with the evidence of her husband's betrayal, the woman had gone to a lawyer to claim the violation of the marriage pact and to call her husband to account. The problem is that the woman, with her "accusation of betrayal" went to the psychologist, not to the divorce lawyer. Hence the problem arising from the demand: for instance, the controlling relations that the woman may establish with the psychologist, if the latter collusively sets up a relationship based on the woman's complaints about the betrayal and on the alliance in condemning the husband's actions of betrayal. This is a relationship that may repeat, though in different terms, the one the woman had with her husband.

Let us now move on, with one further comment: the woman talks about a relationship where the collusive dynamics established with her husband seem to be based on the control–secrecy binomial. According to the woman, the husband is able to have affective and sexual relations only if they are played out in a secrecy that is made possible by the control exercised by the wife, who seems to receive gratification from her control over her husband, forcing him to have infantile affairs conducted in secrecy. The collusion collapsed when the secrecy ended and the husband's extra-marital affairs emerged into the light of day. Hence the anger and the feeling of failure experienced by the wife, as well as the excuses and promises not to do it again on the part of the husband. It is therefore understandable that the woman felt the need to confide in a psychologist: her previous silence had permitted the control - secrecy collusion, and this now seems clear in the mind of the woman, who cannot accept the return to the previous *status quo*, demanded by the husband. Perhaps for the first time the woman feels the need for a relationship in which affectivity can be thought and not acted out in collusive dynamics. She also feels that this thought about the emotions is impossible with her husband, who is somehow tied to a transgressive secrecy as the only way of experiencing emotions and affectivity.

In the viewpoint we are putting forward, the object of analysis is the relationship in its various forms and not the single person with his diagnostic characteristics or the features of the inner world. If one considers the demand from this angle, the lines of development of the demand itself can also be identified: the relationship described in the there and then and repeated in the here and now in the relationship with the psychologist, is based on the denial of *strangeness* Controlling the other, like complaining, are forms of behaviour involving fantasies of *possession*, not of *exchange* with the other in a relation of *strangeness.* What the demand presents as the ongoing problem is whether the woman and the psychologist can set up a relationship of exchange, in which each can experience the other in the dimension of strange otherness. Within the exchange relationship, it is possible to reflect on what the demand presents as a problem.[3]

4. – Characteristics of Clinical psychology

We will now make some comments that we feel might help to characterize Clinical Psychology as consultation in the area of general psychology.

4. 1. - Clinical psychology is an area of professional practice by psychologists, before being a theory of a single technique that can be defined in one single way.

This is so in Italy, as well as in the rest of Europe and in most western countries.
This means that the demand addressed to psychologists, in the "clinical" area, creates a sort of de facto state that seems more important than the possible definitions of Clinical Psychology given by psychologists themselves. Different people, groups, and organizations can go to the clinical psychologist, for the most varied problems. What matters is the fact that Clinical Psychology seems to be a sufficiently clear and univocal reference point for this range of problems.
Clinical Psychologists, on the other hand, are the main component in the psychology profession. Enrolments in degree course leading to Clinical Psychology are the highest in a great many Italian Psychology Faculties. Research into the profession of the psychologist constantly show that the clinical branch is the main one among psychologists practising the profession.

4.2. – Being the psychologists' professional area, Clinical psychology is systematically identified with Psychotherapy.

This is a very important point, which can be seen to be a result of Law n° 56/89, setting up the psychology profession in Italy.
In Law 56/89, article 1 defines the profession of the psychologist, while article 3 lays down rules as to access to the practice of psychotherapy for psychologists, as well as doctors[4]. Due to historical reasons and to the tradition of the psychology profession, the "clinical" profession has been destructured, as article 1 envisages, and the foundations have been laid for the vast majority of Italian psychologists gravitating in the clinical area to become eligible to practise psychotherapy. Think of the poor standing of the

[3] On this, see Carli R., Paniccia R. M. (2003), *Analisi della domanda*, Il Mulino, Bologna. [Analysis of demand:].
4 Let us recall the two articles of the law just mentioned:
Art. 1. The profession of psychologist includes the use of instruments of research and consultation for prevention, diagnosis, activities of qualification-requalification and of support in the psychological domain, aimed at persons, the group, social organs and communities.
Art. 3. The practice of psychotherapy is dependent on a specific professional training to be carried out after the degree in psychology or in medicine, through courses of specialization of at least four years duration , which provide adequate training in psychotherapy, activated under the decree of the President of the Republic, 10 March 1982, n. 162, at University schools of specialization or at institutes set up for this purpose, accredited under the procedures as per article 3 of the same decree.

psychology profession until the 1970s: in 1972, when degree courses in Psychology[5] started, there were little more than 200 psychologists in the whole of Italy; at the end of 1994 there were about 23,000 psychologists on the official register, while by 31st December 2005 we had already reached 53,063 registrations, with a higher and higher rate every year. This rapid growth of the psychology profession has not been accompanied by adequate professional training, sufficiently organized and detailed for the various areas of the demand potentially addressed to psychologists by society. Article 3 of the above law was included in order to safeguard the tiny minority of "orthodox" Italian psychoanalysts who did not want to be considered part of the psychology profession and who, thanks to this law, felt that the moment had arrived for official recognition of the profession of "psychoanalytic" psychotherapist deriving from medicine and more generally from psychology. In reality, at the beginning of the 1970s Italian psychoanalysts saw, in their profession, people coming from the most varied backgrounds and academic training: obviously doctors, but also magistrates, social workers, Arts and Philosophy graduates, architects. The same thing happened for those calling themselves "psychologists". Article 3 stated that from that moment on, to access the profession of psychotherapist (with the implication that psychotherapy was equal to "psychoanalysis") one only needed training as a doctor or psychologist. To practise psychoanalysis, one had to attend a course of at least four years that required specific training, for the protection of patients from "wildcat" psychoanalysts. The lawmakers did not foresee the fact that article 3 would lead to a huge expansion of private schools, recognized by the state, for the training of psychotherapists: today there are about 300 of them. Similarly they did not foresee the explosion of the psychotherapy profession in Italy: from a few score in the early '70s, the number of psychotherapists has reached about 45,000[6] today, if we consider both the psychologists and the doctors registered in the official lists which are part of their respective professional rolls. It seems important to underline that this expansion of psychotherapy was the result of the lack of concrete and credible proposals for the psychology profession from within the Universities; but it was also the cause of this lack of proposals[7]. It was in the frenzied, confused beginnings of

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5 Degree courses in Psychology were set up at the Faculty of Magistero (an Italian university faculty offering a degree in education) with the D.P.R. of 21 July 1971, n. 183, in Rome, and with D.P.R. 5 November 1971 n. 279, at Padua. D.P.R. 6 February 1985 n. 216 makes a change in the teaching of degree courses in Psychology with the introduction of five-year courses, divided into a two-year. Introductory course which is propaedeutic and in the final three years divided up according to the course: general and experimental Psychology; Psychology of Development and Education; Clinical Psychology and of the Community; Psychology of Labour and Organizations. In November 1991, after the restructuring of the Faculty of Magistero, which had previously run the degree courses in Psychology, the Faculty of Psychology was established in Rome. In November 1992 the Faculty of Psychology was set up in Padua. In 2002 there was a fresh reform of university studies, known as 3+2: Psychology too will organize three-year "professional" courses followed by two-year specialist courses, which complete the studies for the conferral of a proper Degree in Psychology. That year, in Rome the "old" Faculty of Psychology was separated into two faculties, Psychology 1 (a mainly general and clinical course) and Psychology 2 (a mainly dealing with social aspects and work). In 2006 in Italy there are 49 three-year degree courses e 52 two-year specialist courses.

6 A rough calculation, due to the lack of secure data. About 65% of those registered on the psychologists' roll get onto the list of psychotherapists (35,000); in addition about 10,000 doctors are recorded on the same register at their professional body.
By this, we do not mean to say that there are too many psychotherapists in Italy; what is lacking is a real evaluation of the need for psychotherapists in our country, although we have reached a rate of 0,80 (nearly one) for every 1000 inhabitants. A lot of psychologists qualified for psychotherapy are actually underemployed today: they do jobs that could be done not just by people not qualified for psychotherapy, but also those without a psychology degree. *The problem does not lie in the "too many" psychotherapists, but rather in the fact that the only occupational area that Clinical psychology seems to open to its graduates is psychotherapy*.

7 On this see: Carli R., Cecchini M., Lombardo G. P., & Stampa P. (1995), *Psicologi e Psicoterapia: oltre la siepe*, FrancoAngeli, Milano, (*Psychologists e Psychotherapy: beyond the hedge).*

the degree courses at Padua and Rome – two cities where there was no professional tradition of psychologists – that teaching from the experimental tradition was melded to that of the doctors (psychoanalysts and systemic therapists) who were "hired" to teach in the degree courses, in the absence of other psychology practitioners.
This identification of Clinical psychology with Psychotherapy has had highly significant consequences:

a – the need to anchor Psychotherapy to some form or dimension of "distress", "suffering", "disorder" that, in the style of medical practice, justifies the intervention of the psychotherapist.
This has meant that Psychotherapy has been assimilated to the notion of "cure" for some disorder, aiming at the "heal" of the disorder. In this way, clinical psychology training a-critically adopted textbooks about mental illnesses that had been compiled in the psychiatric domain. These texts were used for students of Psychology, and for the state qualifying exam for entry into the psychology profession, without the slightest critical orientation, in spite of the obvious contradictions between what they stated and what is proposed by theory and theory of technique in the psychology domain.

b – the individualistic leanings of the practice of clinical psychology – psychotherapy.
Cure and healing are notions that, being closely related to similar medical concepts, have to do with the single individual. The leaning to individualism, taken alongside the idea of cure, involves the implicit assumption of *conformist models* to be aimed for through the psychotherapeutic action. Clinical Psychology in this sense risks becoming the *longa manus* of the social power in whose interests it is to control and to bring uniformity to behaviour and cognitive systems. In this way deficits are corrected, in the hypothesis that the Clinical Psychologist can bring those who "deviate" back to the straight path (literally: straight road = orthodoxy).

c – the notion of psychotherapy is a very broad umbrella, giving shelter to a series of psychotherapeutic techniques that have the characteristic of defining – in a strictly auto-referential way - not only clinical practice, but also the problem that the practice can deal with.
This is due to the fact that within the psychotherapeutic techniques that are strong on theory, theory of technique is also the theory underlying the problem. Strong psychotherapies are therefore able to handle a problem only after transforming it, according to the theory of technique underlying the therapeutic intervention itself. The same problem can, in short, be transformed to make it consistent with the theory of psychoanalysis technique, or cognitive or family-systemic technique.

d – the individualist approach, closely connected to the different techniques and aiming at problems interpreted autoreferentially, has led to a loss of attention for problems of other kinds and for other types of demand that cannot be dealt with by applying psychotherapy techniques in an orthodox way.
In this way, Clinical Psychology has paid and is paying heavily for its a-critical identification with psychotherapy. Think, for instance, of the crisis situations in which populations, or social groups and family members can find themselves following natural disasters or wars. Think of the major issue of the integration of different cultures into the same social context, or the question of customer satisfaction on the part of service sectors in the domains of energy services, traffic, telecommunications systems, banking and insurance services, and the Public Administration. Think of the adaptation by schools to provide the type of training required in their local area. Think of the families of the mentally ill and the social system they are supposed to re-enter, often abandoned by all, with no help or support, in the difficult task of (above all) living with the mentally ill person and arranging his/her social re-integration. Think of the health system and of the change it would have to make to be at the service of the citizen, and not locked into a inward-looking medical culture. In addition, think of problematic relational situations like

the clinical case briefly described above, and of the reductive way they may be handled if they are considered in an individualistic model. The examples could go on; it is obvious that Clinical Psychology is restricted and impoverished if it is confined to a psychotherapeutic function dealing with single individuals via a specific technique, often out of step with the cultural perspectives of General Psychology.

4.3. – Clinical Psychology can use individualistic models as well as models of the relationship.

The intervention in Clinical Psychology is set up and organized by the relationship. For instance the relationship based on client's demand and the relationship based on constructing a client's self-commission; the relationship underlying psychotherapy; the therapeutic alliance as an a-specific factor for psychotherapies; the counselling relationship, organizing interventions in the health field, the relationship established by the clinical psychologist each time he enters the intervention process, with a group of patients, with a school class, with middle or top management of a manufacturing or service firm, or with the members of an immigrant community. The examples could, once again, continue.
The issue that interests us here, on the other hand, is not linked to the fact that the clinical psychologist works with relationship. It is linked, instead, to the theory of technique underlying the relationship. We feel that within theory of technique there are *individualistic models* that define the relationship as the result of the meeting between individuals described and known as individuals; or *models that look at the relationship as such*, that describe it and survey it experimentally. If the aim of the intervention is the modification of the "other", whether it be an affective or cognitive modification or a modification of the affective symbolization of reality, or a behavioural modification, then the theory of technique can only be individualist. An example can be given by the "substitution of the severe Super Ego with a less severe, more tolerant auxiliary Super Ego" in a neurotic patient, in line with Strachey's proposal[8]. *The relationship can be seen as a means for a change that strictly and univocally concerns the individual*. In these cases the relationship is discussed with the use of individualistic categories and models. An example comes from the idea of "therapeutic alliance": defined by Lingiardi and Colli, for instance, as "interactive dimension referring to the capacity of the patient and[9] therapist to develop a relationship based on trust, respect and collaboration and aimed at dealing with the patient's problems and difficulties"[10]. It is interesting to notice that the dimension is called "interactive", but that interactivity is then seen as the result of the "capacities" of the patient on the one hand, and of the therapist on the other… This relationship is therefore based on individual factors, with the relationship itself being determined by the dimensions of one and the other.
There is no modelistic vision that looks directly and univocally at the relationship, rather than at the individuals who determine it. In the case of individualist perspective, this is a legitimate, and in a sense useful, vision; however in this way it is not the relationship in itself that is considered, but rather the relationship as the result of what two (or more) individuals do, experience and feel.
Let us think about this question. Being allies means having a mutual contract based on a shared vision of reality. It is not possible to define alliance as the attitude, behaviour or feeling of a single person or of more individuals. The dimension of alliance excludes

[8] We use here the term used by Strachey to explain the therapeutic value of psychoanalysis. See: Strachey J., The nature of the therapeutic action of psychoanalysis, *Int. J. Psychoanalysis*, 15, 127-159, 1934.
[9] Our italics. It recalls the title of a treatise on Social Psychology: Krech D., Crutchfield R. S., Ballachey E. L. (1962), *Individual in Society* – A textbook of Social Psychology, McGraw – Hill, N.Y.
[10] The article we refer to is: Lingiardi V., Colli A., *Alleanza terapeutica: rotture e riparazioni*; which can be found on the internet site *Psychomedia* at the following address http://www.psychomedia.it/cpat/articoli/38-lingiardi-colli.htm.

individuality. Alliance involves a pact, a decision that is connected to the relationship. An alliance is a way in which the relationship is expressed. On the other hand, the alliance involves reference to a third thing which is the alliance itself. Two or more people are not allied if each of them adopts specific, idiosyncratic attitudes and forms of behaviour. The alliance exists apart from single attitudes or behaviours: *it is characterized by the relationship and not by the single individuals,* even though they relate to each other.
This applies even more to the notion of therapeutic alliance: a term that specifically defines the relationship between patient and therapist, not the patient and the therapist. It is therefore reductive to ask the patient or the therapist if there "exists" an alliance between them. The alliance is connected to their relationship, not to the impressions or evaluations of one or the other.
In Clinical Psychology, in my opinion, we have stopped at models concerning the individual. Models concerning the relationship are lacking.
We have mentioned above the consequences of this absence. Here I would like to recall the origins of the individualist models and of those concerning the relationship. Behaviourism, in the sense of a behavioural response to a stimulus, is the matrix of individualist conceptions in psychology: behaviour, in fact, is an idea that has to do with the individual; the social system, in the behavioural perspective, is the sum of the individuals responding to an environmental stimulus. In contrast, the relationship is typical of the Gestalt school, which envisages the construction of reality (perceptive but also emotional) based on elaborations of the stimulus, contemplating a relation with reality. Hence constructivism, hence the Freud's first topography, and French psychosociology, to arrive at our proposal of the construct of collusion and analysis of the demand. Clinical Psychology was begotten by the two sides, theoretical and experimental, of general Psychology: behaviourism gave rise to the therapy of the same name and then to cognitivism in all its branches; Gestalt gave rise to constructivist schools, to the earliest psychoanalysis and to the construct of "the mind's unconscious way of being", to the psychosociological intervention, and to symbolic interactionism in its psychosociological aspect. The former look at the individual and his/her mental system, the latter at the relationship and its clinical implications I think these are the two areas, compatible but unyielding with each other, that establish Clinical Psychology, from the point of view of theory of technique.

5. – Presumption of normality of the clinical psychologist – psychotherapist.

Let us consider an implication of the individualist perspective in Clinical Psychology with interesting reflections in the culture of those who practise this profession.
There is the tendency to assume as "true" the hypothesis that Clinical Psychology should deal with difficult people, and therefore with people who depend on the psychologist and on the defining knowledge, often erroneously called diagnosis, that s/he may have of the difficult other. If the other is difficult and goes to the psychologist, then it is a foregone conclusion that *the psychologist, thanks to his cognitive power and at the same time in order to legitimate this power to know and to classify the other, must by definition be free of problems.* Notice that this is specific to this view of psychology, and also to psychiatry; not to surgery, orthopaedics or paediatrics. Let us see why: a surgeon who operates on a gastric tumour must have a good operating technique, but nobody expects him to be free of tumours and in particular of gastric tumours. An orthopaedic surgeon who treats a scoliosis certainly does not have to guarantee that he, in turn, has a healthy spine without scoliosis. But a clinical psychologist who treats a person affected by panic attacks "cannot" be affected by the same disorder, or by other problems mentioned in the Diagnostic and Statistical Manual of Mental Disorders (DSM). It is somehow presumed that the clinical psychologist, like the psychiatrist, should be "normal". This *presumption of normality* must be guaranteed by years of study, by personal experience of psychotherapy, by the supervision of the clinical cases handled at the beginning of his/her professional career; in short, by a long period of training. The

future clinical psychologist that wants to practise psychotherapy must agree to undergo a long period of training, often extremely long due to periodical refresher courses, in order to achieve recognition of his/her membership of society. It is this membership that serves as the guarantee of normality, and therefore as a guarantee of being free of disorders which would cast doubt on the investigatory and therapeutic consultation with a person who is "ill".

Not enough attention has perhaps been paid to this presumption of normality of the clinical psychologist, necessary when one adopts the individualist perspective and defines psychotherapy or the psychological consultation as a treatment for people who are disturbed, ill, suffering, with psychological distress, affected by mental disorders, or other similar definitions. This presumption of normality, associated with the knowledge of the other implied by the psychodiagnosis – however it is understood or defined – structures a specific relationship of acts of power. This acts of power envisages the dependence of the person who "is ill" towards whoever will take action to heal him/her, therefore to bring him/her back to the norm[11]. This presumption of normality is not only in the expectations and the identity of the clinical psychologist, of the psychotherapist or of the psychiatrist. It is also the fundamental component in the expectations that the social system has towards those who have to or who can work with psychological suffering. The social expectation of normality seems to be the price the clinical psychologist must pay, in view of the great power s/he is handed with the assumption of dependence on him/her by the person who needs his/her treatment.

This assumption of normality (or, if you like, of conformism) is in our opinion one of the main factors producing the process of *deformation* in the clinical training in psychology, when it is inspired by the individualist paradigm. Presumptuousness, emotional distance, false modesty, an attitude of omnipotence, the tendency to act like an oracle, affected willingness and serenity, a falsely benevolent smile always ready to appear on the face, an eerie calmness, all this and much more characterizes our clinical psychologist ready to take care of the diseased "other", starting from his competent "normality". We should be asking ourselves, like Said[12], *how to save our humanity*. In other words, how to avoid,

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[11] The etymology of *normal* refers to he who adheres to the norm; in Latin, norm means "square" as a measure; 'normal' applies therefore to the person who "is made using the square, is at right angles"; hence rectitude or foreseen of normality. In short, the adjective 'normal' describes the person who conforms, who is in the form foreseen by predefined expectations; *the affinity between normal and conformist is very clear.*

[12] Said E. W (1975), Orientalism, Pantheon Books, N.Y.; [trad. it. (1991), Orientalismo, Bollati Boringhieri, Torino. Some brief introductory comments, to understand the quote].

The Author is referring to the speech given by Arthur James Balfour in the House of Commons on 13 June 1910 about the problems of Egypt.

The preceding facts are well known: in 1869 the Suez Canal was opened, which further increased Egypt's already important strategic function; in opposition to the increasing attempts at foreign interference, an anti-European, nationalist movement emerged in 1882, led by Ahmad Arabi Pascià, Minister for War, which rebelled against the subjection of Egypt; this was the pretext for the English military occupation of the same year: after defeating the Egyptian nationalist army at Tell el Kebir, England took full control of the Canal and the country; in 1884 the Berlin conference recognized the existing state of affairs.

Balfour spoke in the Commons to overcome internal opposition to English domination in Egypt. One MP, Robertson, had asked what right England had to assume such an air of superiority towards Egypt and the peoples that England had decided to call Easterners. Balfour took up the same question, finding a logical, faultless answer in the *knowledge* that the westerners had of that civilization, from its origins to its decline. "Knowledge means rising above the immediate, leaving one's own narrow confines, to welcome that which is remote and different. The object of such knowledge must be intrinsically knowable; it may well be a "fact" that changes and develops as civilizations do, but it must be fundamentally and even ontologically unchangeable. Possessing the knowledge of a body of this kind means possessing the body itself, dominating it, and having full authority over it. And having authority means denying it autonomy – political autonomy, if it is an eastern country – because "we" know it, and it can exist, in a certain sense, only insofar as it conforms to that knowledge. British knowledge about Egypt is Egypt, for Balfour; and the power of

on a par with the English colonialists, the hostility implicit in the tendency to divide humanity into people who are ill, difficult and suffering, on the one hand, and people who claim to be normal, on the other. We can also ask ourselves about the widespread contempt and irony with which psychologists, and in particular clinical psychologists, are seen. The contempt is all the stronger and clearer, the more the psychotherapists who have achieved fame and power in a specific context are praised and idealized. It is as if ambivalence, evoked by those who work clinically with the mind, behaviour, and the adaptation of "others", can be facilitated in a split investment, where people legitimated in their normality are respected and esteemed; while aggressiveness is directed at the person who is seen as a "usurper" of this rare gift of normality, a sort of mystificator who is rejected and scorned. On the other hand, as we know, the respect and admiration emerging from a process of splitting can easily be turned against the one who receives it, thanks to the ease of transferring aggression. It should be remembered that the splitting produced by ambivalence involves a radicalized investment of the emotions in "partial" objects, which can easily be confused, and always remains under the domination of the destructive component in ambivalent emotion.

6. – Conclusions

"The M-PSI 08 sector includes the competences related to the study methods and the techniques of_intervention which, in the various operative models (individual, relational, family and group), characterize the clinical applications of psychology in different contexts (individuals, groups, systems) for the solution of problems. In the areas of the health service, health, psychological distress, and psychological aspects of psychopathologies (including psychosomatics, sexology, and drug addiction), these competences, extended to psychophysiology and to clinical neuropsychology, are addressed to the analysis and solution of problems through operations of evaluation, prevention, psychological rehabilitation and psychotherapy".

This is the description of the scientific and disciplinary contents of Sector M/PSI 08, under the name of Clinical Psychology, as defined by MURST (D.M. 4 October 2000, enclosure B).
Let us look at the key words in the definition, which reveals two inner "spirits", or if you like two viewpoints, condensed into a real compromise.

The key words in the *first paragraph* are: study – intervention – individual – family – group – applications – persons – groups – systems – solution – problems.
As one can see, it is about *problems* and *intervention*.

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knowledge is such that it makes disputes on the superiority or inferiority of this country or that one, futile. Not that Balfour would dream of denying British superiority and the inferiority of Egypt; he simply takes them for granted, and puts aside a view he considers banal, in order to examine the more interesting question of knowledge." (cfr. pp. 38 and 39).
Along with Balfour, Said repeatedly mentions the position of Lord Cromer, the highest British authority in Egypt from 1882 to 1907, on the issue. "The easterner – for the English governor in Egypt – is irrational, decayed (or worse, degenerate), infantile and <different>, just as the European is rational, virtuous, mature, <normal>" (cfr. p. 46). Again, and Said's note is significant for us: "Knowledge of the East, emerging from a position of power, in a certain sense *creates* the East, the easterners and their world" (cfr. p. 46).
Later (cfr. p. 52) Said wonders: "Can one divide human reality, which actually seems so divided , into cultures historical heredity, traditions, social systems and even different races, and save one's own humanity from the consequences? With "save one's own humanity form the consequences" I am referring to the possibility of avoiding the hostility implicit in a division of this type, like that between <us> (westerners) and <them> easterners.

The scenario changes, greatly, with the *second paragraph*: health – health service - distress – psychopathologies – psychosomatics – sexology – drug addiction – clinical psychophysiology – clinical neuropsychology – problems – interventions – evaluation – prevention – rehabilitation – psychotherapy. Here the terms *problems* and *intervention* reappear, and with this one might wonder the reason for the further specification. This specification sees the appearance of the words: *psychopathology* and *psychotherapy*.

But the context changes, one might object. Before there was an "individual, relational, family and group" context; now the context is the "health service" with the related context of "health".
How strong the medical model is! One wonders where psychosomatic, sexological problems, drug addiction and psychological distress (sic!) appear, if not in individuals, families, social groups and organizational relations. What need was there, then, for the second specification? The scenario changes, because *psychopathology* and *psychotherapy* are mentioned.

Yes, but what is the difference between the *problems* (first paragraph) and the *psychopathology* (second paragraph) indicated as domains of Clinical Psychology?
And what is the difference between the intervention (first paragraph) and *psychotherapy* (second paragraph), indicated as working methods in Clinical Psychology?
Nothing, if you think about it. And yet the two definitions are very very different.
The first, when speaking of problems and of intervention, uses terms that refer to *psychological models*. These are models, as we saw before, that attribute the reason for the clinical psychologist's intervention to the lived experience of persons, groups or social organizations. If the clinical psychologist intervenes in problems brought to him/her by the client, then it is the analysis of the demand relationship that enables the clinical psychologist's intervention to be organized and guided.
The second, albeit with the fig-leaf of the "psychological aspects of the psychopathologies", uses terms and definitions that are part of *psychiatric language*, opening the way to that fuzzy, hybrid dimension that we call psychotherapy. And there is further confusion: on the one hand the writer of the definition indicates that the object of the psychological intervention is the - one might say - official psychopathology, broadened to include psychosomatics, sexology and drug addiction; on the other hand, s/he recalls the psychotherapeutic intervention (though with the complement referring to evaluation - in other words to diagnosis - to prevention and to rehabilitation, which are all ways of intervening related to art. 1 of the law 56/89). Yes, but how many clinical psychologists in Italy today define themselves as rehabilitators, diagnosers, or dedicated to prevention? And how much do the forms of psychotherapy, in their strict self-referentiality, have to do with psychopathological nosography? If one maintains the importance of psychopathology in the health service domain, then it would be correct and consistent to indicate forms of treatment that are closely connected to the psychopathology itself. Now, what psychopathology is directly involved with psychoanalytic psychotherapy? And what psychopathology is suited to systemic family psychotherapy or to cognitive psychotherapy? If, as is commonly believed, the choice of the form of psychotherapy is independent of the psychopathology present in the person, group of organization, why does the definition we are discussing link psychopathology and psychotherapy together? Is it merely a matter of the incompetence of the definition writer, or is there something else? For instance the need to please the lobby of the psychotherapy schools?
Whoever wrote the definition could have stopped at the first sentence, which would have said all that was useful for clinical psychology. Adding the second sentence, with the repetition of the terms "problems" and "intervention", creates ambiguity that contributes to misunderstanding and confusion between the psychological and the psychiatric - or more generally medical - dimensions. It should be remembered that psychopathology, especially in its more obvious meaning as it appears in the DSM in its various editions, does not belong to Psychology at all. The DSM could also be said to belong only

marginally to Psychiatry; the latter has formulated far more sophisticated classifications and guides for the description and the proposal of a pathogenesis of mental disorders than the Diagnostic and Statistical Manual of Mental Disorders. The real difference lies in the specification of the contexts within which the definition applies: in the first sentence no domains are specified, and the aim is to define research and intervention within Clinical Psychology. In the second sentence a specification is added concerning "the fields of health and the health service, of psychological distress, of the psychological aspects of psychopathologies", as if the solution to the problems of individuals, groups and systems could assume different versions if the same problems were considered in the health service domain. Perplexity over this definition remains very high, as does the need for its reformulation. It is to be hoped that this will be done as soon as possible.

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