The Politics of Clinical Psychology and/or the Clinical Psychology of politics

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Introduction

This paper is a synthesis of some of our recent observations on the particular way in which we are trying to reconceive and redefine some areas of Clinical Psychology.
Firstly, we feel it necessary to briefly give the premises of the context and the epistemological and methodological frame within which we consider and structure clinical work.
As we have already said and written elsewhere, from our point of view psychology in general and Clinical Psychology in particular should be primarily conceived as sciences of context, of intervention, of change and of living together, involved in project-building, in conceivability, in achieving transformations of the *status quo*, and above all should have the power to identify and analyse the obstacles involved in living together; to identify what inhibits dialogue between subjects, different subjectivities, and the experience of intersubjectivity; in short, to identify all that threatens living together (cfr. Carli, 2000). We maintain that this way of conceiving the psychologies makes them constitutionally "politically committed".
The expression "politics" is used here to indicate the complex psycho-social-cultural dimension reflecting the specific modalities in which people in a community conceive their relationships, represent living together, the Other, the different, the community itself, and the effects that these representations have on the well-being of each person (the only real objective of clinical work).
When we think of psychology primarily as *psychology for politics*, we are not referring only to the importance of the *political context* in people's psychological life or to the clinical-psychology read of the dynamics at work in psychopolitical groups (certainly important aspects that should be studied). We feel, however, that thinking of politics only in these terms risks becoming a "sterile practice", unless one is able to provide politics, like science or the art of governance, with the tools to interpret and intervene in the social world. In fact, *politikè* is also *techné*.

What tools for Clinical Psychology?

For years now clinical psychology research and the related fields of application have had the great merit of understanding the profound social, cultural, and political transformations underway in our communities in such a way as to re-design and expand the tools of intervention and the settings, which have developed in very different directions but always in keeping with the scientific history of Clinical Psychology.
In our view it is right to pay special attention to all strictly clinical issues such as the personality theory, psychopathological models, the area of methods designed for consultation, diagnosis, therapy, individual and group structure and organization in its varying aspects. The promotion of conditions of socio-pycho-biological well-being is also one of the qualifying and unifying points in the clinical way of being and feeling. But equally important is the particular attention to be paid to anthropological, cultural and social occurrences and to the fundamental role that collective facts have in the individual's personality growth. In fact, these *collective facts* determine the conditions of psychological and existential well-being or malaise. The attention, which becomes a specific sensibility towards everything related to *political feeling*, must also focus on the ways in which sociality and shared life in common develop and take shape on the mental space occupied by *political feeling* both in each individual and in the community to which one belongs and which represents one's frame of reference (cfr. Di Maria & Lo Piccolo, 2005).
This way of conceiving and of structuring clinical work makes us very critical, firstly towards the models of psychotherapy (there are very few, in fact) that are still vicitms of the classic individualist

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stereotype, “that looks at the behaviour of the single individual, his belief system or his motives as if the single person existed, characterized by this series of variables, *independently of the context in which he lives”* (Carli, 2004, p.107, our italics). But we are also critical, on a second level, of the models that see clinical intervention exclusively as a space for overcoming psychic suffering, remaining anchored to a vision of the intervention that envisages that it is sufficient that the future patient intends to follow treatment (usually so as to suffer less) for the psychologist to accept his demand. From this point of view, as in the ideas of Napolitani (2006), we believe that the time has come to make a clear distinction between clinical practices based on diagnostic criteria and aimed at a social re-adjustment of the patient and practices based on developmental criteria and aimed at developing the creative potentialities of the patient constrained in a normalizing straightjacket. We also believe that the time has come to distinguish between a modality of entering into relations with the patient by simply identifying the patient’s need (as an expression of a vacuum that must be filled), and a modality that sees need “as the unique and unrepeatable way in which the patient’s story coalesces”, and that as such should certainly be re-conceived, but always respecting its “expressive” capacities.

As a study group we have been trying to reflect for several years on this second level (cfr. Di Maria & Lo Piccolo, 2005). Our efforts are increasingly directed to a redefinition of Clinical Psychology that can free itself from the medical or medicalistic model, and overcome the widespread idea that there exists someone (perhaps a psychotherapist, very competent and well trained) with the capacity to eliminate suffering from the horizons of human existence.

We want to put forward the hypothesis (perhaps more authentic) that suffering, as such, is an irreducible existential condition, just like feeling joy, loving, taking pleasure (without having to necessarily share Buddha’s basic priciples).

Returning to our first level, this means that the ultimate goal of clinical practice, and in particular of psychotherapy, is to shoulder the burden, in order to reclaim and transform the elements of destructiveness present, potentially or in fact, in the bonds between man and his world, and above all, his context (since suffering is always related to contexts, from which it arises, takes shape, and is expressed).

Then we may happen to find that acting in a non-destructive way also symptomatically improves the quality of our existence, we may *discover* that we can suffer less, and also better, in a way that is not empty and sterile, apart from acting destructively; this is in a sense only a side-effect of good clinical practice, not an objective principle, albeit not to be despised, but totally to be wished for. But the primary objective of clinical practices is not anaesthesia and freedom from pain. This is certainly not a great new discovery, but we forget it too often.

Freud’s dual drive theroy, the basis of the second topography, is already strongly impregnated with this, like Bion’s whole discourse, which centres around the construction and breaking of affective bonds.

Of course there is a specifically analytical way of dealing with suffering. This is through the construction of a therapeutic alliance, listening and waiting, to give the patient all the time he needs to settle down in the analytical relationship, to reconnect the broken threads of his story and of his existence, to *refresh himself and lick his wounds*. Very striking and effective is the metaphor used by Corrado Pontalti on this point, of the foreigner Ulysses shipwrecked and welcomed by the Phaeacians; he must first of all be looked after, fed, washed, and honoured before he can start to tell his story (cfr. Di Maria & Lo Piccolo, 2005).

There is a specifically analytical way of dealing, with due caution and awareness, with all the destructive parts of affects and bonds, with respect and hope and above all with no judgemental or guilt-inducing attitudes.

But the real gamble that we take every time in the therapeutic relationship is that of making it into a workshop for learning to recognise emotions and affectivity and to deal constructively with bonds and relationships *with our own world and with Others*.

We believe (to finally return to the first comments we made) that clinical psychology practices must also centre on this. Practices for strengthening the *polis* are needed, both in its more group-analytic meaning of affective mental space for the planning of a shared future, and in the more traditional meaning of the community of reference; the intrapsychic and the interpsychic are in no way separate worlds to be treated with epistemologies that isolate and divide the contexts of human existence.

As group-analytic research first showed, our mind is not just inside us, and nor is our feeling. The human identity is displaceable and permeable, it moves and is shaped through affective bonds and deep relationships. It dwells in affective bonds and deep relationships. Internal and external organization are in mirror-image. And all this is not easy to visualize and to learn to control.
This is the inescapable question for a good clinical competence today, to carry out effectively the work for which we are increasingly held to account by society. Whether we are required to deal with psychic symptoms in psychotherapeutic contexts, or whether we have to carry out "preventative" interventions in absolutely a-typical contexts like city streets and squares, we are always called on to deal with bonds and relationships, of their formation and their daily management.
This is an analytical model of *psychology for politics*, which can profoundly transform present models of psychotherapeutic intervention. A *psychology for politics* is here seen above all as the procedure for managing relational contexts in local communities, aiming at the care and the strengthening of the quality of life and of the communities, by learning to convert destructive elements into creativity.
On the basis of what we have said so far, for some time we have felt the need to identify the streets, squares, outlying suburbs, as the new settings (stages) to carry out clinical interventions, especially with teenagers in difficulty. We are seeking a possible new way of conceiving the city, as a place where it is useful to meet every day in order to revitalize it and to experience it (totally unknown dimensions until a few years ago, when certain streets were only settings for violence, degradation, or simply existential boredom and relational vacuum) and where it is possible to experience a new form of sociality.
All this obviously implies a heavy workload and sophisticated competences, certainly different from those required by analysts in their own professional practices.
It is a matter of level, which however is legitimately determined by the demand for intervention. The competence that we are required to utilize and to convey to the users and those who commission our interventions concerns the understanding and maintenance of affective bonds, and of the social pact at various levels. And it is also a vision of political practice starting from the needs of the weakest, of those who have been given less opportunity, to guarantee them an extra existential prospect. This too is involvement in politics.

Threats to living together and Clinical Psychology

Above we have mentioned the fundamental question inherent to the so-called threats to living together and therefore to the relationship between Us and the many Others that we come into contact with in the course of our existence (not only professionally). We feel that this question, like the one posed above concerning the psychological interest in the weaker sectors, inevitably opens the way to another fundamental question, to which as psychologists for politics, we give top priority.
As we said at the outset, for some years our study and research interest, but also in intervention, has concentrated on the exploration of and the relationship with *Otherness* and consequently, on understanding what psychological-relational space is occupied by the *other* (and the groups he represents) in our mental field. Above all, we are interested in the obstacles deriving from living together, in what hinders *dialogue* between subjects and different subjectivities and the experience of intersubjectivity.
These considerations are one of the starting points that gives rise to our interest in phenomena like prejudice, racism and discrimination (seemingly far removed from clinical work in the strict sense), as viewed by Carli (2000), real threats to the *polis* and to the *need for living together*[1] and

[1] In the preface to the text *Psicologia della convivenza* by Di Maria (2000), indicating and describing the three components, *systems of belonging*, *the stranger* and the *rules of the game*, which he feels give rise to "living together", Carli writes, "The systems of belonging are the symbolic apsects of relationship based purely on the affective symbolization of the other; in other words, they are the social systems organized around the denial of strangeness" (p.11). And again: "The stranger is the other, what is outside family systems, it isthe diversity that must be explored and known, not taken for granted. In this sense, one admits living together when one proposes knowing strangeness (p.11).

expressions that refer to a single dimension, consisting of the *rejection* or the *denial* of the stranger and of his *citizenship*, i.e. the right to share the community, its collective goods and services, and to be recognised as a member of the *polis*.
What place does Otherness occupy in our mental field? Why does the Other, the different, be it the foreigner, the homosexual, the mentally-ill person, still cause so much fear? Why, even though we are increasingly sure that the Other is a inner necessity, that intersubjectivity is the fabric of existence of subjectivity, that the relation with the Other is part of our relation with ourselves, do the great drives to make war, to exterminate populations, to erect real or symbolic walls actually seem to derive from the "pathological" relationship that we establish with difference and with the Other?
Our research seems to confirm that this is connected to the more and more worrying increase in attitudes and behaviours that are strongly discriminatory, but also to the tacit consent towards these behaviours and attitudes on the part of many seemingly democratic citizens. This research also seems to confirm the increasingly authoritarian tendencies of certain individuals aimed at strenuously defending their traditional values (preservation of *in-group* norms) and the consequent perceived threat towards anybody (foreigner, homosexual) who proposes alternative values, attitudes or life-styles (cultural conservatism).
In keeping with this, our current research intersts lie not only in the strictly clinical world, but also in the study of so-called *Implicit Anti-democratic Tendencies*, i.e. new dogmatisms and new authoritarianisms that together form real social pathologies, or *patokenòsi* (shared pathology), whose wash back effects on the individual's quality of existence are extraordinarily obvious. It is no coincidence that today our patients talk to us (also through dream symbolism, cfr. Hopper, 2003) of new fears, new instabilities, new feelings of being threatened, of a clearer need for authority and guidance, that they express new rigid, dogmatic identities, fearful of exchange with the *Other* and with the different (as if the *other* and the different were potential enemies to our limited but seemingly reassuring sense of belonging).

Conclusions

We believe that there is a more and more urgent need to reopen a profound space for reflection on politics, on man as a political being. The same urgency applies, however untopical it may seem, to a space for reflection on the *polis,* seen both as the broader mental context of which all happenings are part, and as a shared planning space for the human community. In this sense clinical psychology as *action-research* can aspire to become the science of the *polis*, as a permanent space for the construction of a group culture for groups, of a culture of solidarity and a thought of differences. This would be a permanent workshop for the mental *polis,* in which reciprocal differences could be contained, comprehended and elaborated. Only if the new, the unknown, the different are known, comprehended and elaborated will they lose their sense of obscure threat and anguish, to become a stimulus for debate, knowledge and growth.
And it is perhaps inevitable to take, as the point of departure, serious reflection about ourselves as a scientific community and to move towards the construction of a culture of the *polis* of clinical psychologists. But such a culture can be built only by relinquishing the need to define ourselves through the attachment to a particular model, a particular theory, or a particular technique.
The construction of a clinical method along the lines we have tried to outline – a scrupulous correlation between theory and practice made possible by a fully conscious use of a theory of technique including both psychotherapeutic and socio-organizational competences – can favour the transition towards a competence-based culture, through which to define one's own criteria of belonging to a mature scientific community. In fact, only by having at our disposal a clearly defined scientific and professional field with which to identify is it possible to detach ourselves from the labels of sameness, typical of cultures of attachment, to move towards an identity defined by a project, in other words an identity based on a culture of competence and membership.

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