Psychology profession, clinical psychology, psychotherapy. Specificities and boundaries

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Submitted: 27th March, 2023
Accepted: 28th March, 2023

Abstract

In the Italian context, the psychology profession is regulated by a particular legal framework, which establishes that (a) a set of expert functions (e.g., psychological diagnosis, rehabilitation) are exclusively reserved to the psychology profession (b) psychotherapy is defined a second-order function reserved to psychologists (and practitioners) having a 4-year specialization after the master degree in psychology. This specific institutional framework raises the necessity of a threefold differentiation. First, the need to set clear scientific boundaries between professional psychology and other non-psychological forms of professional/expert practice (e.g., counselor, mental coach). Second, the need to clarify the specificity of the psychology practices operating in the clinical field with respect to those operating in other fields of intervention (e.g., school, community). Third, the need to model the

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articulation between the clinical psychologist and the psychotherapist. The paper provides a model to operate such a differentiation. Though motivated by and focused on the peculiarity of the Italian context, the current paper offers considerations that may transcend that context and be of general interest.

Keywords: Psychology profession, clinical psychology, psychotherapy.

Introduction

The psychology profession operates over a very broad range of phenomena and issues, in response to many forms of demands made by a plurality of social actors – e.g., individuals, groups, companies, institutions. In most – if not all – of the many domains of intervention where the psychology profession is active, other professions and expert functions are present, sometimes as complementary resources, sometimes as overlapping and competitive suppliers (e.g., social workers, trainers, human resource managers).

It is therefore important to have a clear definition of specificities and boundaries between the different professional and expert functions as well as between the functional profiles and levels inside the psychological profession. This paper is meant as a contribution in this direction. The document reports the conclusions reached by the working group created by the authors, in response to the request of the National Council of Italian Psychologists which asked for a scientific-technical opinion, as to how to "*establish and define the activities of prevention, habilitation, rehabilitation and support in goals, methodology, procedures and actions in psychology with particular attention to the clinical setting, and regarding the same dimensions in psychotherapy*".

Thus, the paper focuses on the Italian context, where the psychology profession is regulated by its own particular legal framework, which establishes that (a) a set of expert functions (e.g., psychological diagnosis, rehabilitation) are exclusively reserved to the psychology profession, and (b) psychotherapy is defined a second-order function reserved to psychologists (and practitioners) having a 4-year specialization after the master degree in psychology. This specific institutional framework raises the necessity of a threefold differentiation. First, the

need to set clear scientific boundaries between professional psychology and other non-psychological forms of professional/expert practice (e.g., counselor, mental coach, clinical pedagogue, clinical sociologist, philosophical counselor, etc.). Second, the need to clarify the specificity of the psychology practices operating in the clinical field with respect to those operating in other fields of intervention (e.g., school, community, legal contexts, sport, marketing). Third, the need to model the articulation between the basic and specialist profiles of professional practice in the clinical field – namely between the domain of competence of the clinical psychologist (where a Master's degree is the level of education required to practice) and that of the psychotherapist (where a 4-year specialization is the requirement for practicing).

Though motivated by and focused on the peculiarity of the Italian context, the current paper offers considerations that may transcend that context and be of general interest. Our aim is to foster debate on the specificity of the psychology profession – including psychotherapy – and on concepts and methods by means of which psychology practices can regulate their dynamic intertwinement, both among themselves as well as with other expert functions.

The paper is broken down into 3 parts. As a preliminary stage, the Italian institutional scenario is outlined. Then, the specificity of clinical psychology practice is discussed. Finally, the distinction between clinical psychology and psychotherapy is addressed.

Scenario

Methodological premise

The clarification of the psychology and psychotherapy boundaries should be based on the idea that it should serve the interested parties (professionals, Orders, institutional agencies) to regulate professional praxis in a public and reliable manner. It is therefore necessary that the distinctions between psychology, the clinical field and psychotherapy, besides being valid from a theoretical-empirical standpoint, should be applicable to concrete cases – i.e., to answer questions such as: does professional conduct x, *by reason of its ostensible and documentable characteristics* a, b, c, fall within the functions that the law considers

to be the exclusive domain of the psychologist? Does it concern the clinical scope of that professional's act? Is it an act that falls within those that the law reserves for the psychotherapist?

Thus, it is not enough to make theoretically grounded conceptual distinctions; it is also necessary that such distinctions be anchored in objectifiable findings, reference to which puts the actors involved in a position to interpret and classify concrete cases. Incidentally, such anchoring becomes difficult to achieve due to the contingent nature of professional action – that is, to the fact that the meaning of the practitioner's action does not reside exclusively in the operations that substantiate it (e.g., conducting an interview, administering a test) but in how these operations interact and combine with each other within and according to the context determined by the user's request and the organizational and institutional conditions of the intervention.

Normative context

Consideration of the boundaries and structure of the psychological profession must necessarily take into account the specificity of the normative scenario governing the profession in Italy. Law 56/1989 establishes the professional figure of the psychologist, without further differentiation. In Italy, therefore, the psychologist is a single professional figure, qualified to practise in any field of intervention, to deal with any problem/requirement (except for psychotherapy, the practice of which is tied to the achievement of the level of specialized training).

The lack of normative differentiation of the professional figure reflects the conception (and practice) of the profession prevalent in the Italian context at the time Law 56/1989 was formulated. At that time the psychological profession was seen as substantiated by intervention methods and techniques of general applicability, transversal to the different fields of intervention.

The Profession's functional profile

Nowadays it should be recognized that while the domain-general dimension of the psychologist's functional profile is an inherent characteristic of the profession, the latter is not limited to that. In fact, the psychological profession is also qualified by two other, domain-specific dimensions necessary for the modulation/tailoring of professional action because of the context/phenomena/problems addressed:

- *sectoral technical skills* – relating to the specificity of the problems/phenomena on which one is intervening – for example: a motivational interview and a psychodiagnostic assessment interview share methodological and technical aspects (e.g., models for interpreting the question) but require different conducting criteria, due to the context in which and according to which they are exercised (purposes, organizational conditions);
- *interface skills* – relating to knowledge of the organizational-institutional frameworks of intervention (e.g., norms, standards, lines of development, organizational models and dynamics, timelines) – for example: a psychologist who intends to work in the legal context needs to know the qualifying standards of expert witness texts, the procedures in which they are embedded, the way they are interpreted and used by commissioners, and the implications potentially associated with them.

It can be reasonably assumed that, since the late 1980s, rather than the general component, the role of domain-specific skills within the psychology function has increased – and continues to increase – because of the progressive differentiation of social, institutional and production systems.

From a complementary standpoint, it is worth noting that the relevance of domain-specific competencies is both reflected and further nurtured by the structure of undergraduate training in psychology. Most psychology degree courses share the structure that combines a generalist phase (three-year segment) and a sectoral differentiation phase (master's segment). Almost all of Italy's master's degree courses are anchored to a domain of intervention (health, clinical, work, education, community), thus aiming primarily at the promotion of domain-specific knowledge and skills.

Implications

The two contextual elements recalled above are dialectically related to each other. On the one hand, the norm delineates the profession of the psychologist as a *unicum*; on the other hand, under the impetus of the progressive differentiation of social systems, the psychological profession (with the system of academic training at its base) is becoming increasingly sectorialized. Both elements are structural data that cannot be ignored or eliminated and therefore need to be brought back to synthesis.

To do so, it is useful to enhance the distinction between the two levels of the normative system that regulates the psychological profession – the statutory provision (56/89) and the deontological norm. The terms of this distinction are specified below.

a) The qualified psychologist has legitimacy to work in any field of intervention. This means that "clinical psychologist" is a concept which is void of a legal profile: only "psychologist" exists under Italian law, without further specification. Rather than clinical psychologist, it is therefore appropriate to refer to *clinical psychology* (as well as school psychology, legal psychology, sport psychology, tourism psychology), meaning by this term a specific sectoral field of practice of the psychology profession. In short, there is not the clinical psychologist but the psychologist working in the field of clinical psychology.
b) The specification of the field of operation is relevant, however, because of the combination of the deontological norm and the progressive sectoral differentiation of the profession. The deontological norm binds the professional psychologist to work exclusively within the areas for which he or she has the necessary skills. On the other hand, as mentioned above, sectoral differentiation means that an (increasingly) significant share of skills are domain-specific. Consequently, deontology makes the differences between domains of intervention salient because of the different functional profiles of competence associated with them.

From this standpoint, the psychology profession is configured similarly to the medical profession, differing from the engineering profession. In fact, we know that the law does not preclude the qualified physician from intervening in any kind of health-related problem; the

physician, however, is subject to the deontological requirement to operate "in science and conscience", that is, exclusively within the perimeter defined by the skills he or she has. In contrast, the engineer's license is not general, but sectorial: each engineer, by virtue of the class of degree he or she has acquired, qualifies in a field of practice. Sectorization is thus, in this case, established at the level of law, rather than deontologically.

In short, broadening the reasoning to the deontological norm leads to the conclusion that it is useful to supplement the two "classical" differentiations – psychological profession vs. non-psychological practice and non-specialist psychological practice vs. psychotherapy – with a third "horizontal" differentiation, internal to the psychological profession, between the areas of intervention, which is cogent from the deontological standpoint.

Psychology profession and clinical psychology

The specificity of the psychology profession in Italy

The distinction between the psychology profession and non-psychological professional practices is the subject of previous National Council of Italian Psychologist's previous documents, to which we refer for an in-depth discussion. Systematically, these documents ground and derive the specificity of the psychological profession from its anchoring in psychological science. The action of the psychologist in the various fields of intervention, including the clinical one, is based on psychological theories that may be differentiated in methods and techniques (psychoanalytic, cognitive-behavioral, systemic, social-cognitive, etc.) but have in common the scientific study of the individual and group mind, and the relationship between intrapsychic, interpersonal and social dimensions, between subjectivity, intersubjectivity and relationship. Psychological science has specific theoretical and cultural foundations, and it is to these that professional psychology refers.

This link with the common foundations of psychological science distinguishes the psychologist working in the clinical field not only from the counselor and the clinical pedagogue, but also from the

medical clinician and the neuroscientist who studies the foundations of the mind (in the same way it distinguishes the psychologist working in sports from the mental coach, the psychologist working in organizations from the other counseling figures active in that context, the psychologist working in schools from the pedagogue, etc.).

The curriculum provided by the bachelor's degree and then by the master's degree ensures the psychologist a common and specific foundation that the university training of pedagogues, physicians and neuroscientists does not contemplate: their intervention is therefore based on other scientific assumptions and related methods. Incidentally, this means there is a specificity of clinical psychology compared to clinical medicine with which it is integrated in a system of care that is increasingly multi and interdisciplinary (and in perspective, transdisciplinary), respecting the fundamental biopsychosocial approach that characterizes modern health systems.

The clinical psychology field. Background

The clinical psychology field has been the subject of several definitions, both at international and national levels.

According to Division 12 of the American Psychological Association, clinical psychology aims at the scientific study – integrating social science, theory and clinical knowledge – and applications of psychology regarding the understanding, prevention and intervention concerning stressogenic and dysfunctional psychological problems, and the promotion and maintenance of psychological well-being.

More specifically on the application level, APA considers clinical psychology as follows.

Clinical psychology is the psychological specialty that provides continuing and comprehensive mental and behavioral health care for individuals, couples, families, and groups; consultation to agencies and communities; training, education and supervision; and research-based practice. It is a specialty in breadth – one that addresses a wide range of mental and behavioral health problems – and marked by comprehensiveness and integration of knowledge and skill from a broad array of disciplines within and outside of psychology proper.

The scope of clinical psychology encompasses all ages, multiple diversities, and varied systems[1].

The statement of clinical psychology activities in the Italian context is also expressed by the recently revised text of the definition of the scientific-disciplinary field Clinical Psychology (for the purpose of university research and teaching) made by the Italian Ministry of University:

The scientific-disciplinary field of Clinical Psychology includes skills related to study methods, teaching and interventions in the different clinical and care contexts and operational levels (individual, relational, family, group, institutional), throughout the life cycle. Said skills concern the scientifically recognized applications of psychology in the fields of health, healthcare and hospital, pain study and therapy, forensics, psychological distress and psychopathological conditions (psychosomatic, sexological, stress, addiction included). They are aimed at the prevention, understanding, and treatment of the aforementioned conditions through wellness and health promotion interventions, identification of protective and risk factors, psychodiagnostic assessment, psychological rehabilitation, and psychotherapy.[2] *Skills in clinical psychophysiology and clinical neuropsychology are included, as well as neuroscientific skills referring to bio-psycho-social pathogenetic models. Methodological skills, tools and techniques related to the aforementioned areas are included.*

Finally, it is useful to recall the definition developed in the context of EFPA/EuroPsy.

Clinical Psychology constitutes one of the widespread areas of professional research and intervention in psychology whose domain of application concerns problems of adaptation, behavioral disorders, states and conditions of malaise and suffering for the purpose of

[1] Cf. https://www.apa.org/ed/graduate/specialize/clinical, where further specification of the objects and areas of clinical psychology are given.

[2] Psychotherapy is included here in the clinical psychology definition as a teaching topic introducing the nature of the object.

assessing and taking care of them by psychological means to facilitate and support people's cognitive, emotional and relational well-being and development.

In line with the normative definition of psychologist (L.56 /1989), Clinical Psychology is distinguished by the theories, methods and intervention tools aimed at prevention, assessment, habilitation-rehabilitation and psychological support activities, with a focus on understanding individual and collective user demand (couple, family, groups, organizations and community), psychodiagnostics and aid and support interventions, including strictly psychotherapeutic ones (which constitute a particular subset of specialized clinical intervention modalities aimed at more structured psychopathological forms).

Thematic cores of operational interest and clinical research may be exemplified among some such as: the prevention (primary and secondary) of personal distress; early identification and diagnosis of psychopathological risks; cognitive, affective-emotional, psychosocial, behavioral, personality, social and cultural factors that are at the origin of disorders or sustain the condition of distress; emotions and their regulation in relation to health and illness, with specific regard to affective dysregulations; clinical management modalities of different types of individual, couple, family and group disorders; various forms of individual, couple, family and group psychological counseling; the improvement of the effectiveness of psychodiagnostic techniques; ways of managing emotional, relational or decision-making crisis situations arising in various stages and contexts of life; the promotion of individual psychosocial well-being and in social contexts (kindergartens, schools, family and work); the design of effective forms of psychological and psychosocial rehabilitation; the evaluation of the effectiveness of aid interventions and health prevention and promotion programs in different social contexts, etc.[3].

[3] https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjV1LHwyfz-AhVyRfEDHQbcCp-sQFnoECA0QAQ&url=https%3A%2F%2Fwww.psy.it%2Fallegati%2Faree-pratica-professionale%2Fpsicologo_clinico.pdf&usg=AOv-Vaw2YvAfNOI0ghx6O_YtHhAmg

The psychological-clinical field

The above definitions are useful in delineating the perimeter of clinical psychology as a domain of the psychologist's intervention. They require, however, to be further specified in a functional key – that is: in terms of specifying the structural features that require a particular profile of domain-specific skills to be treated/modulated/governed.

Let us start with a general definition, which deepens those mentioned in the previous paragraph.

Clinical psychology is the exercise of the psychological function of knowledge and intervention within the clinical domain, the latter as the set of typical and atypical intrapsychic and relational, individual, couple, family, group, and institutional processes that govern the lives of individuals and groups in aspects related to subjectivity and its externalization (e.g., sense of personal accomplishment, the use of cognitive and emotional skills for the purpose of active adaptation, and the ability to entertain meaningful and beneficial relationships for well-being).

This general definition helps us identify two structural characteristics that delimit the clinical field, thus distinguishing it from the other fields of the psychological profession (social, community, educational, organizations, legal).

Object. The psychological clinical field is defined by the object of intervention. More specifically, the clinical scope consists of the intrapsychic, interpersonal, and contextual processes, factors, conditions, and phenomena (the contexts and dynamics of primary, couple, and family relationships; but also of groups operating in institutions and organizations; community dynamics) related to and/or substantiating states of psychological distress and discomfort. Where the attribute "psychological" refers to the determinants of distress (e.g., a limited capacity for mentalization that critically affects the ways of entering into relationships with others) and/or the subjective content of the experience (e.g., a condition of acute psychic suffering related to a loss).[4]

[4] Two clarifications are useful. First, the object neither conceptually nor factually

The anchoring to "psychic distress/illness" is important in that psychological science has developed a specific and differentiated profile of psychological knowledge and skills in relation to it. Possession of a large portion of that profile is therefore a necessary deontological condition for carrying out psychological interventions having psychic distress/discomfort as their object.

Setting. Psychological clinical intervention is conveyed through professional operations that take place *through mediation and/or as a function of settings operating at the interpersonal/microsocial level* – primarily through interaction with the user, conducting groups, and participating in networks of interpersonal exchanges. This distinction

coincides with the demand, the goal and the user. It is not necessary that the request to the psychologist concerns the condition of mental distress. In fact, not infrequently, individuals with psychic distress make demands to the psychologist that reflect bias in the interpretation of their problem (e.g., the request to act on a family member seen as the critical element in need of psychological intervention). The goal of clinical psychological intervention also does not necessarily have to coincide with countering the condition of distress/discomfort. Indeed, in various cases, clinical psychological interventions use the demand motivated by distress as a starting point and a leverage for interventions geared toward promoting conditions of well-being and development of the person. Finally, the condition of distress should not be confused with the client who is the suffering from it. This means that the clinical setting is not characterized by a specific type of user. In fact, on the one hand, the recipient of the intervention is not necessarily one suffering the distress (e.g., counseling parents aimed at treating their child's distress). On the other, a person who is suffering distress may be the target of an intervention that does not specifically address that condition. For example, vocational counseling aimed at a worker who is also suffering psychological distress is not a clinical intervention. Incidentally, this last observation allows us to highlight a relevant feature of clinical psychological intervention – it is nonspecific and concerns organizational and production contexts. This means that it focuses on the psychological dimensions (e.g., modes of psychic functioning, beliefs, subjective condition, behavioural patterns) related to the psychological distress/discomfort that the subject experiences globally in his or her life context, rather than on the psychological dimensions functional to the quality of role performance in a given organizational/productive context (e.g., the psychological factors associated with organizational commitment or sports performance effectiveness).

Second, psychological distress and discomfort do not imply psychopathology. While it is true that a psychopathological condition is often associated with subjective distress, it is equally true that in many circumstances states of distress/discomfort do not imply atypical forms of mental functioning that can be diagnosed in terms of psychodiagnostic categories.

has a significant implication at the level of skill profile – the purposeful regulation of interpersonal/microsocial settings requires distinctive interpretive models, methods and techniques designed because of the subjective and intersubjective processes that characterize such human forms.

It is worth pointing out that the two anchors presented above should not be considered in absolute terms. Rather, each should be understood as indicative of a polarity on a continuum. Some interventions are clearly situated on such polarities – for example, an intervention to support a person who goes to the psychologist because of a situation of psychological distress is an example of a practice characterized by the combination of the individual distress/setting polarities. In other cases, however, the intervention is in a less polarized position. For example, in some cases the intervention is at the same time focused on the discomfort felt by the individual and on the components of that discomfort that interfere with role performance. Again, as already noted, in some cases the psychologist does not work directly with the persons suffering the distress, thus in an interpersonal setting, but in terms of advice given to agencies (e.g., a hospital ward, a school) engaged in taking charge of the distressed state of a particular category of subjects.

The intermediate conditions now recalled do not invalidate the sense of the proposed delimitation; rather, they highlight how in several cases the psychologist operates in cross-cutting and overlapping areas of intervention, and therefore needs a well-structured skills profile, combining models, methods and techniques related to several areas.

In summary, clinical psychology – like school psychology, legal psychology, occupational psychology, etc. – is not an autonomous professional system: this is what the ordinal law states, which makes no distinction within the psychological profession, except for psychotherapy. It is an aspect of the general psychological professional function, defined according to the characteristics of the object and setting of intervention: problems to be addressed, on the one hand, organizational formats of professional action, on the other.

Thus, the specificity of the clinical field does not concern the general functions exercised (e.g., prevention, support for individuals and

social groups, increasing the efficiency of psychic functions and the subjective well-being that follows), nor the methods used (e.g., interviewing, observation, testing), which are common to the psychological profession in all its forms (in fact, we speak of health, or rather health psychology).

Forms of the psychological-clinical field

Before addressing the specific area of psychotherapy, which is the subject of the next section, it may be useful to give an illustrative (non-exhaustive) list of functions that the psychologist can perform in the clinical setting.

- Diagnosis and rehabilitation in clinical neuropsychology.
- Diagnosis and treatment of neurodevelopmental disorders.
- Functional assessment and rehabilitation of intellectual disability.
- Clinical assessment of case-problems in school settings (to be referred to appropriate interventions beyond the scope of the school psychologist).
- Interventions on performance anxiety, in school and other educational settings.
- Support for families with members with disabilities, hyperactivity, special educational needs, adopted children, chronic conditions, dementia.
- Diagnosis of personality and family and group dynamics.
- Diagnosis and preventive intervention of the transition from Mild Cognitive Impairment to dementia.
- Diagnosis and intervention in services for different forms of addiction.
- Evaluation and intervention of "mental training" on stress in sports settings.
- Diagnosis and intervention on work-related stress in companies.
- Analysis and interventions for the treatment of chronic pain.
- Palliative interventions in oncology and hospice settings.
- Discomfort prevention interventions at all levels and in all contexts where it is implemented.
- Training in knowledge of clinical and dynamic, and neuroscientific

theories referring to pathogenetic models to non-psychological professionals (teachers, lawyers, social workers, physicians, nurses, speech therapists).

Psychotherapy

Within clinical psychology, psychotherapy is distinguished as a specific area of specialized activity, for the practice of which the law provides for level III training, lasting four years, as for medical specializations. Psychotherapy is considered a part of clinical psychology that, while sharing its basic assumptions, is specifically defined as "Treatment of mental or personality disorders, by psychological methods" (Oxford English Dictionary). Referring also for this to the APA definition, psychotherapy is

psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns. Psychotherapy may be provided to individuals, couples, families, or members of a group. … The psychotherapist is an individual who has been professionally trained and licensed to treat mental, emotional, and behavioral disorders by psychological means[5].

Incidentally, the reserve introduced by Law 56/89 of psychotherapeutic activity to professionals with a four-year specialization appears to be consistent with the APA definition, where the former can be understood as an operational definition of the criterion of professional qualification indicated in the latter.

The psychotherapy field

We saw that the general epistemology, the scientifically grounded attention to the subjectivity of people, groups and social institutions, and the methods used are common to all professional psychology.

[5] https://dictionary.apa.org/psychotherapy

Therefore, the definition of psychotherapy cannot be based only on the characteristics of professional action, but also on the determination of the *object* that motivates and defines the finalization of the specialized professional act.

According to this perspective, we identify the treatment of psychopathology as the primary, reserved and qualifying object of the psychotherapeutic function. Unless giving the term a merely metaphorical meaning, the term "psychotherapy" denotes the class of psychological forms of therapy. Consequently, as a *therapy*, the meaning of "psychotherapy" implies that it addresses a class of forms of pathology: pathologies of a psychological nature. This formulation does not exclude the fact that psychotherapy, as is well known, *also* addresses complex forms of existential, relational and environmental distress and suffering. When we state that psychotherapy is the (psychological) treatment of pathologies of a psychological nature, we mean to describe its function in its differential and exclusive aspect. This, of course, is not inconsistent with the fact that "the more includes the less" – that is, the psychotherapeutic function also deals with forms of distress that are not explicitly psychopathological. Examples could be many, for example, a couple's psychotherapy where the two people undergoing therapy do not necessarily have a psychopathological disorder; or a boy undergoing psychotherapy because he suffers as a result of being bullied at school.

Returning to the psychotherapy of psychopathological conditions, it should be remembered that the relevant scientific literature recognizes psychopathological conditions and their scientific study as areas of high complexity that require deeper theoretical study, supervised learning of research and intervention techniques, openness to verification of the therapeutic outcome and process, and the use of appropriate skills to carry out such verification. For this reason, psychotherapeutic caretaking requires specialized *caring* (in the sense of treatment) skills, in addition to the *support* skills learned in basic training; specialized skills that – along with practical experience and related supervision in appropriate quantity and quality, as required by the standards for specialization – qualify the psychotherapist's distinctive training and functional profile.

Based on these considerations, the following definition of psychotherapy is advanced.

Psychotherapy is the specialized psychological-clinical professional function responsible for therapeutic intervention on *conditions of psychopathological relevance* (as defined by the diagnostic framework in use at the international level). It acts *by means of verbal, relational, cognitive, and behavioral interventions* (unlike biological psychiatry, which includes pharmacological prescription in its intervention), with the willingness to scientifically verify the effectiveness and efficiency of its intervention, according to the research methodologies that the specific community of reference has purposely developed. In this sense, the psychotherapist tends to specialize in a form of intervention, related to a historical tradition, to specific theoretical models, in specific prevailing areas.

The following identifying parameters of the exclusivity dimension of psychotherapy are derived from this definition. It is to be considered the exercise of psychotherapeutic activity (rather than non-specialist psychology in the clinical setting) when the following conditions are present simultaneously:

(a) interventions are made on both conditions of psychological distress or discomfort and on conditions of psychopathology[6] that have been appropriately diagnosed and assessed as suitable for a psychotherapeutic programme;
(b) that the intervention is planned as psychotherapeutic – that is, has the purpose of treating the psychopathological condition[7] –

[6] It is worth pointing out that where there is a condition of psychopathology, psychological distress/discomfort should by definition be considered a participating element of the psychopathological picture, and therefore subsumed within it. This implies that the psychologist who does not specialize in psychotherapy can work on distress/discomfort, even in people with psychopathology, only on condition that the goal of the intervention does not involve – even de facto – a planned modification of that psychopathological condition. For example, direct action on the distress associated with a depressive condition requires the intervention of the psychotherapist, as such action has as its *object* the psychopathological condition. On the other hand, the mitigation of a state of distress of a person with psychopathology, achieved through the enhancement of the quality of the social network of the suffering person, is an intervention that does not have for its object the formally planned modification of the psychopathological condition, therefore as such achievable by a non-specialized psychologist. The same applies to forms of support for the person with psychopathology, which, however, do not constitute structured psychotherapy in the sense described in (a) – (c).

[7] The distinction introduced earlier between object and user type returns here.

because of a preliminary psychodiagnostic assessment[8], and agreed as such with the client;

(c) that psychotherapeutic intervention – regardless of its duration – is carried out with specialized methods and techniques, based on a precise *psychotherapy model*, requiring *specialized training* and an appropriate *supervision period* of treating patients, families or groups (which is done in Italy in the specialization that allows one to register on the list of psychotherapists). Again, the difference from clinical psychology is not in the overall goal of reducing distress and increasing the well-being of individuals, couples, families, and social groups, but in the *type of problems* addressed, and in the methods that require specific, specialized health-related training.

The fact that the user is suffering from a psychopathological condition is neither a sufficient nor necessary condition for identifying the intervention as psychotherapeutic. The nonspecialized psychologist can work **with** users who suffer from psychopathological conditions, but not **on** those conditions (i.e.: with the goal of modifying them). Supportive interventions are not aimed at modifying the psychopathological condition, but at enhancing opportunities for adaptation within the constraints given by that condition (see previous note). Such interventions therefore fall within the clinical psychology, not psychotherapy, domain. From a complementary standpoint, the fact that the user suffers from psychopathology is not a necessary condition for classifying the practitioner's action as psychotherapy. In fact, there are cases in which the psychotherapist does not directly enter into a relationship with the person suffering from psychopathology, but acts as a consultant to subjects and agencies (e.g., family members, school) that mediate the context of the end user of the intervention. A necessary and sufficient condition for qualifying the action as psychotherapy is therefore that the purpose of the intervention – its function – is the treatment of the psychopathological condition.

[8] The need for psychotherapeutic intervention to be grounded, motivated, and legitimized by psychodiagnostic assessment is a logical assumption of the proposed definition, not an operational prescription. It is obvious that if psychotherapy is defined as the treatment of psychopathology, the intervening professional qualifies his or her act as a psychotherapeutic action by reason of the fact and to the extent that it is exerted on a psychopathological condition, with the purpose, agreed upon with the client, of modifying it. Hence the obligation on the part of the practitioner to acquire adequate knowledge about the existence of the psychopathological condition prior to planning the intervention. Even when not directly making the diagnostic assessment, the professional (whether psychologist or psychotherapist) must define the limits and aims of his or her intervention on the basis of knowledge of the user's psychodiagnostic condition.

References

American Psychological Association (2013). Riconoscimento dell'efficacia della psicoterapia. *Psicoterapia e Scienze Umane*, 47(3), 407–422.

Barkham, M., Lutz, W., & Castonguay, L.G. (Eds.) (2021). *Bergin and Garfield's handbook of psychotherapy and behavior change*. 7th edition. New Jersey: John Wiley & Sons.

Llewelyn, S., & Aafjes-van Doorn, K. (2017). *Clinical Psychology: A Very Short Introduction.* Oxford: Oxford University Press.

Norcross, J.C., & Lambert, M.J. (Eds.) (2019). *Psychotherapy Relationships that Work, vol. 1: Evidence-Based Therapist Contributions*, 3rd ed. Oxford: Oxford University Press.

Wampold, B.E. (2001). *The great psychotherapy debate. models, methods, and findings*. New Jersey: Lawrence Erlbaum Associates.

Westen, D., Morrison, K., & Thompson-Brenner, H. (2005). Lo statuto empirico delle psicoterapie validate empiricamente: Assunti, risultati e pubblicazione delle ricerche. *Psicoterapia e Scienze Umane*, 39(1), 7–90.