Transforming clinical psychology: An ecological and psychopolitical perspective. An Italian and global case

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Submitted: 30th June, 2024
Accepted:16th September, 2024

Abstract

Historically, the field of study and intervention of clinical psychology is the suffering and treatment of individuals, just as the forms through which it is applied are individual. However, its scope, techniques, theories and epistemological assumptions are always interconnected with and shaped by socio-cultural, economic, and political contexts and factors. This paper will summarize some of the underlined critical issues of clinical psychology highlighted in various areas of literature and experienced in daily practice, according to a "psychopolitical" perspective. Subsequently, developmental theoretical and practical trajectories will be outlined that incorporate these critical issues by tending toward an evolution of psychology, aiming to bring its responses closer to the rights and needs of peoples, communities, individuals so as to develop its potential democratic scope and thus enrich its contribution in the dialectical-creative process of active community participation.

Keywords: Clinical psychology, psychopolitical perspective, ecological approach, democracy, psychology profession.

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Psychology as a historical device

The profession of psychologist in Italy is the product of recent socio-historical processes (D'Elia, 2020). The profession arises from a specific cultural, social, and economic system, with the risk of creating (apparent) compensatory solutions (Basaglia, 1979) to the social contradictions of the same system, such as individualism and the disintegration of capital and social networks.

Psychology in Italy, both as cultural practice and a scientific device, is often collectively seen and represented as a private profession due to the law that established and instituted its existence. Law 56/1989, regulating the profession, is the result of a long process of political and corporatist negotiation. The price to be paid for such regulation lay – and still lies today – in the private positioning of the profession, at a symbolic level (the anthropological figure of the psychologist in his private practice continues to exert a cultural hegemony over any other representations), at a material level (just under 7% of psychologists work in the public health service), and at political level (for instance considering the political intervention of the "bonus psicologo"). Psychology, as a device for understanding and caring for the mind, is the result of historical and cultural events (Foschi & Innamorati, 2019), biographical (Atwood, 2001), technological, and scientific (Semerari, 2022). The complex intertwining of these levels generates, moment by moment, specific theoretical and practical modalities influenced by the spirit of the times and by associated anthropological, economic, psychological, and psychopathological hegemonies (Hacking, 2004; Innamorati, 2021).

And what is the object of this device? If madness is the «history of a long silence» (Foucault, 1961), and psychiatry is the discourse of technicians about this madness, then clinical psychology can be considered a technical and cultural discourse on human experience as a whole, not necessarily focused on madness (Foschi & Innamorati, 2020).

It is a discipline that responds to the social, cultural, and scientific need to understand the subject's experience from within, in mentalistic and individual terms. Therefore, the object of the clinical psychology device is the human experience (Armezzani, 2002). Nevertheless, the human being of psychology is not the human being of sociology, urban

planning, architecture, surgery; it is precisely – and it may seem obvious but is not – a psychological human being, the so-called Homo Psychologicus (Fromm, 1971). Clinical psychology can be conceived as the space and time of a specific psychological discourse on human experience; and it is known how the categories of clinical psychology risk being categories of the individual, the atomized and disembedded subject, categories aimed at understanding a dematerialized subject, deprived of a lived body (Husserl, 1999) and a more or less pacified cultural horizon of belonging. It is the space and time of a dialogue, from which emerges a certain discourse, a certain truth, a certain knowledge: the subject's knowledge is reconstructed as psychologized knowledge, mostly intrapsychic. The subject is constructed and reconstructed (depending on the hegemonic psychological models) as a "psychological puppet": his experience read with the categories of the psychic, his thoughts understood with the devices of the mental, his behaviors deciphered as direct determinations of the individual, more or less conscious, will.

This work will analyze historically neglected elements of clinical knowledge, such as the role of inequalities in the genesis of suffering and health, the myth of neutrality, and the diffusion of the associated therapeutic culture. Furthermore, it will address theoretical and practical issues, within a psychopolitical and ecological framework, aiming to contribute to the creation of an enriched clinical psychology able to challenge traditional clinical psychology and its effects on society as a whole.

Growth of clinical psychology and inequalities

The history of the development of clinical psychology is closely related to the global and national socio-economic contexts in which it has evolved, characterized by the Neoliberal culture built around the economistic myth and the belief in the possibility of unlimited growth.

Globally, despite the increased availability and accessibility of psychological interventions, the public's increased familiarity with clinical constructs, and the exponential growth in the number of psychologists, no data demonstrate a significant improvement in the health and well-being of citizens nor does it seem possible to indicate a

substantial change in the social structures that influence and shapes these conditions.

On the contrary, social narratives about the population's health conditions often emphasize, with alarmist tones, a constant deterioration, especially for the younger age groups (Ahn-Horst & Bourgeois 2024). Some authors point out the risk that clinical psychology may contribute to the maintenance of social (Patel, 2003) and health inequalities. Given the argument that «psychology's negative impacts occur despite the good intentions of most psychologists» (Fox *et al.*, 2009), it is crucial to consider the potential outcomes, risks, and iatrogenic effects of clinical psychology. This approach is essential for a comprehensive analysis of the overall impact of clinical psychology on societies. It involves not only evaluating effects at the clinical, individual, or intersubjective levels but also expanding beyond these assessments to understand broader societal implications. Such an analysis cannot rely solely on the epistemological and methodological assumptions typical of clinical psychology, which are inherently limited in understanding higher-order phenomena such as cultural, social, community, economic, and political phenomena, for which different conceptual and operational tools are needed, integrated within an interdisciplinary perspective.

This analysis must be based on defining the field where to evaluate the impact of clinical psychology: the social field, irreducible to the mere sum of individualities. Within this field, applying the lens of social justice (Powers & Faden, 2006), the health of the social body and the organization, as well as the forms, structures, and social processes, can be defined by the equitable distribution of resources – both material and symbolic – and rights, as well as health, among social groups. From this perspective, social, economic, power, health, and opportunity inequalities represent the main obstacles to the health of the social body and the development of democratic societies.

The history of inequalities and their effects on the social body and the living conditions of citizens is well known: socioeconomic inequalities began to significantly increase by the 1970s, following a period of greater equity, in the post-World War II era (Piketty, 2014). This process, associated with the entrenchment of the neoliberal paradigm, led to the disintegration of the social fabric linked to greater inequalities. As a matter of fact, a solid body of evidence (James,

2009; Wilkinson & Pickett, 2009, 2018) highlighted the negative effects of inequalities on societies and the living and health conditions of citizens. In fact, consistent epidemiological data pointed out that more unequal societies are likely to be more violent, more divided and divisive, less cooperative, and more competitive than more equitable societies, which tend to be characterized by higher levels of well-being, health, participation, and social cohesion (Wilkinson & Pickett, 2009, 2018).

In this perspective, a basic assumption, derived from epidemiology (CSDH, 2008) and capable of producing reflections on the ethical and political dimension of clinical psychology and its impact on social organization, is that health and disease, subjectively experienced, are objectively distributed in the social body along a social gradient. The health status varies according to the social position and the set of resources this position makes available. Compelling and incontrovertible evidence suggests that health and well-being are more widely distributed among the more advantaged strata of society: a better socioeconomic status is highly predictive of a higher life expectancy and better health conditions (CSDH, 2008; Wilkinson & Pickett, 2009, 2018). In this context, however, the distribution in the social geography (Curtis & Rees Jones, 2018) of the application of clinical psychology, as a care device, seems to respond to the principle of the «inverse care law» (Hart, 1971), whereby the availability of care varies, especially where market forces are greater, in inverse proportion to need, fueling inequalities. Despite the global greater availability related to online delivery platforms, the scarcity of psychological services in the public healthcare and its impoverishment mean that the real practices of applying clinical psychology are economically more accessible to those who enjoy better economic, social, and consequently health conditions. Therefore, the economic barriers imposed by fees can be conceived as a form of selection, discrimination, and social stratification based on economic factors (Bessone & Sarasso, 2019), increasingly excluding from the right to access to care and health those people belonging to most disadvantaged economic, social, and health groups. In this perspective, to emphasize the impact on social and health inequalities of the distribution of a specific branch of clinical psychology, psychotherapy, the phrase «unequal distribution of psychotherapy» has been introduced (Bessone, 2020). This expression refers to the

potential difficulty of psychotherapy, as a social resource, in responding proportionally to the health needs of the population, which are closely related to social, symbolic, and material resources. Psychotherapy would be more readily available to those subgroups of the population who are less likely to live in circumstances and contexts that constitute a risk factor for distress.

These considerations on the relationship between social structures and the application of clinical psychology highlight specific sociopolitical implications of clinical practices, indicating, from a social justice perspective (Powers & Faden, 2006), paradoxically undemocratic and harmful effects. The same scarce sensitivity of clinical psychology to the distribution of power and social resources has been highlighted not only concerning barriers to access but also in the elective field of clinical practices, that of the relationship, emphasizing the risk that therapists' lack of awareness of social class may lead to unintentionally oppressive and/or classist behaviors (Trott & Reeves, 2018) and a specific social positioning of clinical practices.

The therapeutic culture

However, the widespread dissemination of clinical psychology has undoubtedly produced positive effects on the health of the social body and individuals, bringing many people closer to understanding and exploring their inner world, improving self-awareness, relational dynamics, and their way of being in the world. Moreover, as emphasized in 2023 by the President of the National Council of Italian Psychologists[1], during the conference for the general states of the psychological profession, in order to foster public engagement and investment in psychological interventions, the so-called "psychological well-being" can produce positive effects in the economic and work fields, both personally and socially. Additionally, the process of familiarization and habituation to clinical discourse (Furedi, 2005) has increased the social awareness of the harm caused by some relational modes, fostering the acceptance and recognition of the presence, in the public space,

[1] https://www.psy.it/il-presidente-del-cnop-david-lazzari-a-la-psiche-e-vita-discorso-di-apertura/

of different sensitivities and modes of interaction. This new social sensitivity to differences promotes processes of individual and collective subjectivation (Rose, 2007), in a manner consistent with the ethics of authenticity (Rose, 1990). Indeed, the coexistence of diagnostic labels derived from the DSM and clinical languages and entities constitutes the basis for processes of collective identification with the references provided by clinical systems (Hacking, 1995), also leading to «citizenship projects» (Rose, 2007) and advocacy (Saraceno *et al.*, 2022) with a strong identitarian connotation, with positive effects on the sense of belonging and participation in social organization.

These evident benefits, however, represent only a portion of the broader effects of the pervasiveness of clinical psychology on the social organization and its processes in contemporary societies. Studies on the «therapeutic culture» (Furedi, 2005) allow to grasp the complex and multifaceted consequences at the sociocultural level of the pervasiveness and greater social recognition of clinical devices in industrialized countries, which, in addition to promoting the well-being of individuals, families, communities, and societies, can, in the same way but in the opposite direction, fuel processes of cultural iatrogenesis (Illich, 2004) and social changes that do not necessarily produce health and well-being for everyone.

Following the logic of the "specific counterproductivity" to Illich's works, Furedi (2005) defines the therapeutic culture as a dominant and hegemonic cultural force built around the "therapeutic morality" that shapes the common system of meaning, socializing dynamics of an individualistic nature, characteristic of clinical practices and neoliberal ideology, for instance through the emphasis given on the centrality of the individual and constructs such as responsibility, autonomy, and individual independence. The "therapeutic culture" is the result of the socialization and normalization of ways, characteristic of clinical lenses, of understanding, conceiving, experiencing suffering, and corresponding interventions, whose adoption would extend beyond clinical settings. These modalities are characterized by a shift from «political determinations» to «emotional determinations» (Furedi, 2005) of suffering. In a context characterized by the greater availability of clinical psychology interventions, based on the increasingly shared code of emotionality, these would tend to be seen and experienced as more appropriate for managing, signifying, understanding, sharing, conta-

ining, and countering suffering, compared to different strategies, such as informal, spiritual, or political ones.

The "therapeutic culture" would thus be involved not only in the gradual erosion of other social devices implicated in the management of suffering but also in the phenomena of harmful weakening of social bonds, isolation, and social withdrawal characteristic of contemporary societies, increasingly unequal, where loneliness (Hunter, 2012) is configured as a growing public health problem, to the point of prompting the WHO to establish an ad hoc commission for its management. Furthermore, it has been emphasized how the "therapeutic culture" is connected to a pathologization of everyday difficulties, to the semantic expansion of what is commonly conceived as «mental disorder» (Haslam, 2021, 2016) and of many other terms derived from the clinical field (consider the overuse of the expression "trauma"), and to the pathologization of terms such as "anxiety", often associated with a «semantic context linked to diagnoses, disorders, and symptoms» (Xiao *et al.*, 2023).

Transforming clinical psychology: Overcoming neutrality

That said, we believe it is possible to transform dominant practices in clinical psychology starting from two principles:

- The recognition of the historicity of the discipline;
- The recognition of the limits of the discipline.

Firstly, we need to acknowledge all those historical, social, cultural, and economic trajectories that dynamically and complexly determine our theories and actions as clinical psychologists. Every act we perform, even of knowledge, is closely related to a history and a social and symbolic context from which it emerges. Every thought and theory is not in the vacuum but within the fabric of the material and symbolic determinations of the communities. Theories and practices are imbued with particular visions of humanity, society, health, and illness that are not value-free.

Secondly, while we are satisfied with the increased emotional and

relational sensitivity, and greater individual and collective salience for fragilities and oppressed minorities, it is important to curb the wave of therapeutic culture in which we are immersed. Clinical psychology deals with the mental level of experience. However, we are well aware that the factors necessary to build a person's mental health and well-being often are rooted beyond purely idiosyncratic factors, into the realm of material and symbolic determinations, namely all those rights whose violation generates situations of material and, circularly, psychological stress. This recognition of the historical determination of clinical psychology, acknowledging its epistemological limits and hegemonic tendencies, and attempting to redesign psychological theory and practice in light of these re-cognitions would also facilitate the questioning of one of the founding myths of clinical psychology, which reverberates in its social representation: its neutrality.

The cultural myth of psychology's neutrality act at least three levels of discourse: a more strictly epistemological one (which answers the question of how knowledge is constructed in a given discipline), a purely clinical one (which addresses how the relational process at the core of the discipline is constructed), and a purely political one. Purging the social, cultural, and material determinations from the construction of psychological clinical knowledge exposes us to the risk, at an epistemological level, of falling into a certain type of naïve realism (De Caro, 2004; Della Gatta & Salerno, 2018). We speak of the risk of conceiving the construction of psychological knowledge as the construction of true knowledge, as if (dualistically or monistically) there existed a world outside our perceptions and motor possibilities (Gibson, 1979; Maturana & Varela, 1987; Noë, 2010). The organism and the environment envelop each other and unfold within each other in that fundamental circularity that is life itself (Varela, 1991), and it is for this reason that in this infinite circularity between organism and environment, we cannot ignore all the tensions of life that are not strictly psychological but still possess (if not more) relevance in the construction of human experience.

«Without memory and desire» (Bion, 1973): one of the most famous warnings. This is precisely the risk we run at the clinical level: thinking, first as citizens and then as clinicians, that we have the tools that allow us to empty ourselves of our material, psychological, and cultural determinations to access the mind of the Other in a natural and

authentic way, as if there existed a level of psychological discourse truer than another, as if the mind were ontologically structured in layers of authenticity and truth; as if the clinical psychologist could truly meet the other in a field emptied of economic, symbolic, and social determinations. It is not only a sterile exercise but also a dangerous attempt to bracket all those non-psychological determinations that impact and construct the experience of the subject of clinical psychology: housing, job and economic stability and conditions, access to mobility, respect for minimum hygiene standards, access to the right to housing, gradient of real and perceived safety, gradient of racialization and sexism experienced, and so on.

The founding myth of neutrality has been, for clinical psychology, the bastion around which to build the citadel of its supposed impartial scientificity and citizenship; as if, by adopting a certain naive empiricism, psychology could escape the determinations of time; as if clinical psychology were not both the offspring and, circularly, the progenitor of the material, symbolic, and social conditions of the human beings who have constructed it; as if there were no link between the concrete events of time and the scientific events of clinical psychology. This small fraud of neutrality has evident political implications: if the conditions of health and illness are co-determined by the historical, social, political, and economic circumstances of individuals and communities, how can a neutral psychology fulfill its functions of care and promoting well-being?

Building on Castel's critique of analytical neutrality (1975), partially already extended to the psychotherapy apparatus through the term "Psicoterapismo" (Bessone *et al.*, 2022), the so-called neutral psychoanalyst becomes "socially neutralizable", "technically neutralized by the role they impose on themselves", and "practically neutralizing" invalidating any sociopolitical determination reinterpreted according to the analytical, symbolic, and intrapsychic discourse and level. The attitude of the analyst, the psychotherapist, and often the clinical psychologist, is thus transposed into a relationship where the position of implicit sociopolitical consent becomes the technical rule of neutrality, often presupposing or imposing apoliticism as the normal reference of the situation. This is one of the ways by which psychoanalysis, as well as psychotherapy and clinical psychology, completely overlook the problem of their political and extraclinical

significance. However, this does not erase their political consequences but preserves them, with the risk of consolidating the status quo (Prillentensky, 1989) and preventing analyses in extraclinical terms of the neutrality they are likely to impose and the neutralization they often risk to operate. Using Castel (1975) technically speaking, neutrality in the clinical relationship is the condition of possibility for its functioning, and, politically speaking, it is the political embodiment and the socialization of apoliticism. Nowadays, this happens in a political alignment with the neoliberal ideology, which tends to invisibilize the political element and where political dynamics are obscured and made less evident, contributing to masking the underlying implications, power conflicts (Brown, 2015), and oppressive circumstances.

If, on the other hand, we conceived good health practices as practices of liberation and emancipation from socio-economic inequalities (Barò, 2006; Comas-Díaz & Torres Rivera, 2020), we would need to consider what role clinical psychology could play in promoting these practices and what role it might have in reinforcing the inequalities it should instead address. We have established that the processes maintaining inequalities are not only economic but also social and cultural; and at this point, we can hypothesize that clinical psychology might represent one of the mechanisms legitimizing these inequalities. The naturalization of psychological suffering, its individualization, and the naturalization and legitimization of social circumstances and inequalities mean that clinical psychology reads the mental as a purely intrapsychic level of experience, simultaneously constructing an equally individualistic and falsely natural intervention framework. The radical processes of reification of the mental push clinical psychologists (but also all those citizens imbued with therapeutic culture) to read and understand life's sufferings as purely psychological sufferings, as sufferings of the mind, with the consequence that the more appropriate treatment will necessarily appear the psychological one.

In summary, and with the words of Franco Basaglia (2000): «When one is mad and enters a mental hospital, they stop being mad and become a patient. They become rational as a patient. The problem is how to undo this knot, how to go beyond "institutional madness" and recognize madness where it originates, that is, in life». The political risk of a purely intrapsychic clinical psychology consists of a certain mystification of reality (Comas-Díaz & Torres Rivera, 2020): health and

illness phenomena are read by excluding the material and social aspects that we know to be determining in the construction of both health and illness (WHO, 2014), thus feeding and legitimizing, in this way, a highly unequal status quo that is, therefore, unhealthy for individuals and communities.

To transform clinical psychology from a persuasive tool into one of liberation (Comas-Díaz & Torres Rivera, 2020) and democratic participation, it is necessary to recognize how clinical psychology, as a product of its time, can reinforce the cultural myths that underpin that culture, such as individualism and indifference (James, 2009; Zamperini, 2007). Therefore, we hope that recognizing clinical psychology as a political tool that shapes social discourses around suffering will both enable and be facilitated by the development of an embedded clinical practice – one that is in constant dialogue with both formal and informal knowledge and institutions (such as political parties, associations, neighborhood committees, shopkeepers' associations, public services, social centers, and cultural circles) within the local community. Moreover, the «politicization of the discipline» (Barò, 2006) can be a theoretical tool that makes it possible to build specific clinical practices that acts at a local level knowing the various actors and stakeholders in the community, building alliances with them and facilitating emancipatory opportunities for participation and citizenship (Comas-Díaz & Torres Rivera, 2020). It entails clinical practices that are reactive to the contradictions of its communities and that knows how to respond to them by activating a vast array of appropriate formal and informal actors. For example, we argue that when faced with an individual suffering due to the threat of eviction, a clinical psychologist should know whom to consult in order to collaboratively develop even the most materially adequate response, one that addresses the practical realities of the situation.

In summary, the transformation of clinical psychology envisioned in this work follows two seemingly contradictory paths. On one hand, it actively opposes a naturalistic, neutral, and apolitical view of clinical practice; on the other, it seeks to engage with the dominance of therapeutic culture by politicizing social discourses on suffering, thereby raising awareness of the social determinants of distress experience, and positioning the clinic as a catalyst for political consciousness rather than mystification.

An ecological approach and psychopolitical perspective

As we said, the fact that the growing spread of clinical psychology has undoubtedly benefited many people does not mean that its effects, on the many levels through which the health of society can be analyzed, are exclusively positive. This suggests the need to adopt an ecological perspective (Bronfenbrenner, 1994) on the impact of clinical psychology, going beyond its inherently individual focus. This means assuming that clinical psychology should be considered both as a symbolic and material system, operating at the individual level as well as at the environmental and societal levels. An ecological approach to clinical psychology involves making the environmental effects of clinical psychology as an object of study, encompassing gradually superordinate, interconnected levels of analysis, from intrapsychic to macro, and qualitatively different aspects, such as symbolic, material, or moral, as well as different geographical scales, from local to global. Furthermore, if the outcomes of evaluating the individual level through psychological lenses do not allow for this often overlooked assessment of the ecological impact of clinical psychology, then an interdisciplinary approach is required (Kagan *et al.*, 2001).

For instance, what happens to societies or interpersonal relationships when mental illness-related concepts, such as trauma, depression, and anxiety – introduced by clinical practices and theories – are increasingly used and undergo semantic inflation (Haslam, 2016; Haslam *et al.*, 2021; Xiao *et al.*, 2023)? What happens, at economic, interpersonal or individual level, to families when all members are involved in psychological therapies? Considering the pervasive presence of clinical psychology in society, to what extent does it influence the fact that the emotional distress of many students is rarely seen as a reason for structural changes in schools and is more frequently addressed through clinical psychological interventions? What impact do psychological treatments have on the risk and likelihood of accessing inappropriate, rights-violating pharmacological treatments (Bessone & Firenze, 2024)? What happens to spiritual life in societies or neighborhood where suffering is mainly articulated, understood, and cared for by clinical psychology lenses and interventions? What happens to the public health sector in Italy if most people seek to meet their health and wellness needs through platforms governed by the private sector

and market laws? What are the consequences for individual rights and for the kind of society that relies on a functioning public sector to uphold those rights? What happens in societies when the work of clinical psychologists starts to become socially appealing? What happens as a consequence of the growing increase in online courses on clinical psychology in Italy?

A similar ecological approach to psychology is both similar to and substantially different from that already proposed by Heft (2013). As far as we know, Heft's work emphasizes the importance of considering «human public social life» (Heft, 2013) and human econiches. He highlights the need for an «ecological psychology» (Heft, 2013, 2020) that, from a Darwinian perspective, should be able to go beyond the acceptance of the two related foundational dualisms of classical psychology (environment/mind, natural/cultural world). However, if this epistemological assumption brings him closer to the work of the sociologist Bourdieu (Bourdieu, 2021, 2016, 2015), "the logic of practice" of the latter, despite starting from symbolic considerations, seems to be far from the Heft's work that appears to remain at a theoretical, often abstract level, focused solely on epistemological concerns, being often neither concrete nor pragmatic. Additionally, Heft's work seems to obscure or disregard, from a Marxian perspective, the differences in social power and the power relations and forces present in society, essential for the alignment with a liberation psychology perspective (Comas-Díaz & Torres Rivera, 2020). Moreover, while Heft (2013, 2020) considers the contradictions of psychology as a human system, it does not specifically focus on clinical psychology. His work does not seem to consider the non-neutral role of clinical psychology in the reproduction of social structures and norms, despite highlighting the structural role and ongoing changes within these systems and econiches.

In the field of psychology, approaches that consider the multifaceted, interconnected, and nested ecological impacts of psychology are used both by «liberation psychology» (Comas-Díaz & Torres Rivera, 2020; Barò, 2006) and by branches to which the adjective "critical" has been appended, indicating the possibility that psychological disciplines, such as community psychology (Kagan *et al.*, 2019) or health psychology (Prilleltensky *et al.*, 2003), may have concrete, symbolic, and material iatrogenic effects on social organization. These effects can represent structural forms of power and oppression (Comas-Díaz

& Torres Rivera, 2020; Parker, 2015; Prilleltensky, 2008), maintaining and often legitimating specific dominant structures and processes related to socioeconomic and health inequalities, and violating human rights (Prilleltensky, 1989). Furthermore, based on the analyses provided by the vast field of critical psychology, the need for a critical approach to psychotherapy, psychoanalysis, and counseling in neoliberal states has been highlighted (Loewenthal, 2015).

From these considerations, the term «psychopolitical validity» (Prilleltensky *et al.*, 2008) has been coined, «a criterion for the evaluation of understanding and action in professions dealing with oppression, liberation, and well-being». This criterion consists of «the level of attention given to the role of power in explaining psychological and political phenomena affecting suffering and well-being». The term aims to highlight the interconnection of psychological and political dynamics.

> Affective, behavioral, and cognitive experiences cannot be detached from power plays being enacted at the personal, relational, and collective levels of analysis. Similarly, political contexts cannot be understood without an appreciation of the subjective, ideological, and cultural forces shaping power relations. This dialectic accounts for the term psychopolitical (Prilleltensky *et al.*, 2008).

Prilleltensky (2008) emphasizes the pervasiveness of power in every setting, highlighting how, as health practitioners embedded in a social reality shaped by social forces and power dynamics, we must critically reflect on how we think about and treat the people we work with, as well as on all interactions with members of our community. They underscores that «a primary challenge, then, is to reflect on our own existing practices and scrutinize their effects. A subsequent challenge is to incorporate lessons about power, oppression, wellness, and liberation into everyday practice» (p. 129).

We state that a psychopolitical approach, capable of understanding and intervening in the ecological and political impact of the power conveyed and exercised by clinical psychology, both within and outside the clinical setting, and its inevitable contradictions, should characterized by several principles:

• Positionality, self-reflexivity, and non-neutrality: this involves awareness of one's position in the sociopolitical context, recognizing that clinical psychology is never neutral. Nor can it be. It does not exist in a state of «sociological gravity absence» (Castel, 1975). It requires critically reflecting on one's role and the power dynamics we are part of, understanding how our actions, decisions, theories, and practices influence and are influenced by power structures. This means moving within the field of social justice, using the power derived from one's professional position responsibly, in line with the Universal Declaration of Ethical Principles for Psychologists (IUPsyS & IAAP, 2008).

• Intersectionality and social justice: a psychopolitical approach must be intersectional (Crenshaw, 1989), considering how different dimensions of personal and social identity, and different affiliations (e.g., gender, race, class, sexual orientation, ability) intersect to create experiences of oppression and disadvantage, as well as privilege and social advantage, within specific contexts. It is necessary to promote social justice and collective health (Powers & Faden, 2006) by eliminating inequalities, systemic injustices, and rights violations, in clinical practice and in broader society, conveyed through axes of intersectional oppression, including through theories and practices of clinical psychology.

• Rights-based approach: without denying the criticalities and contradictions of discourses and practices that rely on human rights and the global power dynamics they manifest and enable, clinical practices and theories must ensure dignity and respect for every person and subjectivity, by virtue of our common belonging to humanity and the social determinants of mental health (WHO, 2014). Psychologists must work to support, promote and defend the rights not only of the citizens who turn to them but also promote their autonomy, inclusion, and active participation in community life and in decisions affecting their lives. They must also act to protect the rights and well-being of all vulnerable and marginalized people, working to remove barriers that prevent full enjoyment of fundamental rights in all sectors, promoting the creation of environments and social contexts that ensure dignified living conditions and inclusion for all.

• Non-duality and epistemological pluralism: a psychopolitical approach cannot be based on rigid dichotomies, such as mind/body, individual/society, symbolic/material, theory/practice, public/private, local/global, nature/culture, health/illness, object/subject, but must consider and integrate these dimensions, interconnected with power dynamics, and recognize the interconnection and interdependence of phenomena. This approach must draw on a variety of perspectives and methods of knowledge production, aware of the power dynamics permeating the knowledge construction process (Foucault, 1976), encouraging the integration of different and plural approaches, and considering different levels in a historical and dynamic perspective.

Theories, practices, and processes for transformation

A psychopolitical approach that encompasses these principles allows for capturing the multifaceted effects of clinical psychology on the social body and can be applied not only to its ecological evaluation but can simultaneously enrich the theories and practices of clinical psychology. This can mitigate its often overlooked iatrogenic effects, which may be clinically irrelevant or interpreted on an solely individual/mentalistic level.

While most theories and practices of clinical psychology today use concepts related to power at the individual level, for example, through the expressions "helplessness" or "omnipotence" (often alluding to a pathological dimension), or at the interpersonal level, for example, in relation to power in the clinical relationship and its dynamics, the community of clinical psychologists has also produced models that incorporate many of the aforementioned principles, highlighting an unprecedented attention to the consideration of clinical psychology devices as devices of power, in a biopolitical sense (Foucault, 1976, Rose, 1990, 2007), from an ecological perspective, and to the role of power dynamics in determining conditions of suffering and recovery.

The Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018), for instance, is a model co-constructed by the British Society of Psychologists with the people on whom this model should be applied (i.e., citizens experiencing mental distress, navigating care services, and so-called survivors) in a democratic process of

knowledge construction. It is based on the awareness of the mutual influence of biological, psychological, relational, social, cultural, economic, material, and political factors. In the PTMF, the fully social nature of human beings is considered by integrating the mental dimension of individuals (considered in their identities and social belonging) and the biological dimension, through the relevance attributed to processes of embodiment, material and social circumstances, discourses, narratives, meaning systems, and social beliefs.

The central role assigned to "social and cultural discourses and belief systems, material conditions, and bodily potentialities" from which personal meaning emerges, shaping the operation, experience, and expression of power, threat, and our responses to threat, is not disconnected from the consideration of multiple forms of power (biological/embodied; coercive; legal; economic/material; ideological; social/cultural; and interpersonal).

This allows for a deep incorporation of an intersectional, rights-based approach, assuming that neither emotional distress for individuals nor what counts as a "mental health" need or crisis in any given situation, nor human systems, such as healthcare systems, nor theories and judgments about identifying, explaining, and intervening in mental distress can be neutral or value-free. This sets the scene to consider the iatrogenic power of clinical psychology from an ecological perspective. Additionally, the centrality assigned to power allows "to generate personal, group, and social narratives that help to restore meaning and agency, and along with this, have the potential to create hope, rebuild relationships, and promote social action" in a wider community, social policy, and political context.

Additionally, there are many formalized approaches, such as task sharing and social prescribing, integrating psychological and political, symbolic and material, dimensions and operating within an ecological framework. The value of these approaches is not only operational but also transformative, promoting greater democratization of theories and practices related to clinical psychology, care services, and the broader social organization.

Task sharing (Orkin *et al.*, 2021), used especially in resource-scarce contexts, involves transferring skills, knowledge, and tasks to non-specialized professionals who are trained and supervised by more specialized professionals. This enabling to perform tasks traditionally

reserved for specialists increases the coverage and availability of psychological interventions and challenges the hierarchical nature of knowledge and power, redistributing knowledge-power within services and the community, empowering community members, and legitimizing other social actors. Although this approach has demonstrated its effectiveness in increasing the coverage of psychological interventions (WHO, 2024), one of its main limitations is the type of highly standardized knowledge that can be transferred. In Italy, the primary obstacle to its application is the defensive and corporatist stance of the professional psychology community towards counseling, and the reluctance of clinicians to relinquish part of their power, legitimizing less specialized actors to operate in the field of mental health and psychological care.

Social prescribing (Islam, 2020), which currently lacks a shared definition, is used especially in relation to many chronic diseases and so-called "common mental disorders". It involves integrating clinical, health interventions with socio-community, non-health interventions through the co-construction of an activity plan in the territory, considered as a risk, protective and therapeutic factor. Social prescribing allows for addressing feelings of loneliness of Western societies by promoting social support, especially for vulnerable population groups, from a perspective of social justice and intersectorality, addressing mental health by directly tackling the social determinants of mental health (WHO, 2014), and reactivating social participation processes. The main obstacle to its application (WHO, 2022), particularly in the context of clinical psychology interventions, is the need for personal, organizational, and infrastructural resources that shift the focus of work from the private practice, where it usually ends, to the community and the territory where it is located and towards which it can serve as a bridge.

In summary, task shifting and social prescribing, while not without risks and criticalities, are practical example allowing for integrating an ecological and psychopolitical perspective into mental health, enriching clinical practices that, whether psychological or psychiatric in nature, risk to absorb and monopolize the care functions within contemporary social systems permeated by the "therapeutic culture".

Task shifting and social prescribing have the advantage of potentially transforming care and social systems towards greater democrati-

zation, also through a redistribution of the social power held by clinical psychologists as exclusive bearers of knowledge-power over suffering, extending the boundaries of care from the clinical setting to living contexts, and integrating, at theoretical and practical levels, psychological and political dimensions, and readings and interventions on suffering that reconnect individual, psychic, and symbolic dimensions with material, community, and political ones.

Within an ecological perspective, we must ask ourselves how else clinical psychology can be constructed as a tool for liberation from oppressions. It would be necessary to have tools (like the PTMF) that can read the suffering of individuals and collectives in the most complex way possible, drawing from this reading the basis for building good health practices that can impact not only the subjective level of experience but also, and especially, the material level of oppression and denial of fundamental rights.

Rejecting the foundational myths of the current neoliberal system, i.e., rejecting individualism, infinite growth, competition at all costs, and the naturalization of social contradictions, would allow clinical psychology to carve out a function of social justice, promoting health conceived as a collective condition directly linked to material and symbolic disparities present in a given territory. Rejecting the private mandate and opening up to a political, public mandate of the discipline would allow it to build new practices, impacting the processes of belonging and participation in public life.

We highlighted how the unequal distribution of income and wealth by a few generate a struggle of everyone against everyone else, which, in turn, exacerbates a competitive and unsupportive social climate. These processes undermine social cohesion and capital, and collective participation, making society more fragmented, violent, unjust, and pathogenic. It is within this contradiction that clinical psychology should dwell and move, recognizing its original private-oriented and individualistic mandate and trying to reject it by constructing theoretical and practical frameworks facilitating processes that promote a more equitable distribution of social and symbolic capital, and democratic participation.

Subsequently, we imagine practices focusing on disadvantaged territory and on commodified spaces (squares, streets, parks) accessible and traversed mostly for consumption, to transform these territories

and spaces into places of subjective recognition (Benjamin, 2019). We envision a clinic of social bonds, with a health promotion function (Laverack, 2004), facilitating, with other actors and stakeholders, processes of participation and active citizenship, enabling individuals and communities to rebuild a sense of power, control and agency over their lives, and the feeling of being able to intervene, all together, on those social contradictions generating disorientation, suffering and preventable inequalities.

Conclusion

In Italy, since its private-oriented institution, the constant growth and development of clinical psychology has brought many undeniable advantages to the society and the quality of many lives, enriching them. Nevertheless, it is not without risks, costs and contradictions.

The increase of socioeconomic inequalities since the 1970s is strongly associated with the widespread dissemination of clinical psychology practices and devices that subtly incorporate, diffuse and reproduce the culture from which they derive, thus risking to maintain and not to challenge many avoidable social injustice and promoting the so-called "therapeutic culture".

Clinical psychological, as a device concerning human nature, should recognize its historical determinations, its limitation and, contrary to common belief, the impossibility of being a neutral actor in the democratic social field, or to generate exclusively positive effects, basing this assumption on the outcome on the lives of those having the privilege of accessing it. Furthermore, a broader, multifaceted and complex analysis of the impact of clinical psychology on the whole society, its health and democracy, need an interdisciplinary and ecological approach, starting from a critical consideration about the myth of neutrality and its consequences. Moreover, a psychopolitical account, highlighting the interconnection of psychological and political dimensions and the role of power in shaping it, can foster this analysis as well as transform harmful, epistemological, theoretical, and practical, aspects of clinical psychology. Principles incorporating these assumptions and having the potential to transform clinical psychology by addressing its impact on social assets have been highlighted: positionality, self-reflexivity, and

non-neutrality; intersectionality and social justice; rights-based approach; non-duality and epistemological pluralism.

Then, Power Threat Meaning Framework has been cited as a good practical example of democratic process to knowledge construction and model of distress, embedding the role of social determinants of mental health, power and inequalities as key factors for understanding and acting, conjugating clinical, community and societal level. Subsequently, social prescriptions and tasks shifting are been presented, evidencing them potential to democratize relevant and accessible knowledge and practice about mental health and well-being and expanding the field of intervention on the territory and including other relevant social actors.

Finally, it has been highlighted how the adoption of models, strategies and interventions as such, allows for transforming both clinical psychology and the social space and organization and communities which it is interconnected in a mutually influential relationship, in a health promotion and a democratic and empowering process for all.

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