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CONTENT

The Benefits of Expressive Writing in Group Psychological Counseling with ART Patients

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Abstract

This article investigates the benefits of expressive writing within an integrated model of group psychological counseling for patients undergoing Assisted Reproductive Technology (ART) treatments. The research questions focus on the effectiveness of the integrated model, which combines group counseling with expressive writing, in improving emotional regulation, psychological well-being, and quality of life in individuals facing infertility.

A quasi-experimental pre-post design was adopted with 11 participants undergoing ART treatment. Participants completed questionnaires assessing quality of life, emotion regulation, and depression levels before and after a group psychological counseling program integrating expressive writing exercises. Statistical analysis revealed significant improvements in emotional management and quality of life dimensions. No significant changes were found in perception of medical treatment or interpersonal relationships, suggesting the intervention may have greater impact on individual rather than relational dimensions.

Overall, the integrated model of group psychological counseling with expressive writing appears to be a valuable approach in psychological support

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for ART patients. Further research is necessary to explore its long-term effects and to develop more targeted interventions focusing on couple relationships and perception of medical treatment.

Keywords: Infertility, Assisted Reproductive Technology (ART), expressive writing, psychological support, couple relationship.

Introduction

Infertility represents one of the most complex and multidimensional challenges a couple may face in their life journey. Defined by the World Health Organization (WHO) as "a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse" (World Health Organization, 2018), this condition is not merely a biological issue. Instead, it deeply permeates individual identity, couple dynamics, and the psychosocial well-being of those involved.

Globally, infertility affects approximately 15-20% of couples of reproductive age, with estimates suggesting that 60-80 million couples worldwide are affected (Visigalli, 2011; Volpini & Melis, 2013). In Italy, according to data from the Ministry of Health (2015), around 30% of couples experience infertility, a rate consistent with other industrialized countries. This translates into approximately 100,000 couples per year facing reproductive difficulties, based on the number of annual marriages. Recent data from the Italian National Institute of Health (Istituto Superiore di Sanità, 2023) confirm the persistence of this issue, showing a steady increase in ART procedures, which reflects the growing demand for support among couples facing fertility problems.

The psychological impact of infertility has been widely documented in scientific literature: as noted by Cousineau and Domar (2007), the inability to conceive is perceived as a highly stressful situation by individuals and couples around the world. It triggers a cascade of emotional reactions, including shock, denial, anger, depression, anxiety, and social withdrawal (Visigalli, 2011). These emotional responses are not merely transient but may evolve into

dysfunctional patterns that significantly impair quality of life and overall psychological well-being.

The medical response to infertility is represented by Assisted Reproductive Technology (ART), a set of techniques designed to assist couples in achieving pregnancy when natural conception is not possible. These techniques have evolved significantly over recent decades, thanks to advances in medicine and biotechnology. ART procedures range from first-level interventions, such as intrauterine insemination (IUI), to more complex second- and third-level procedures, such as in vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI). In Italy, ART practices are regulated by Law 40/2004, which, despite numerous modifications following Constitutional Court rulings, remains the central legislative reference for ART in the country.

The evolution of ART in Italy shows continuous growth. According to the Istituto Superiore di Sanità (2023), ART treatments nearly doubled from 63,585 in 2005 to 109,755 in 2022, with the percentage of live births from ART rising from 1.22% to 4.25% of the general population. These figures reflect not only the increasing effectiveness of ART techniques but also the growing demand for support from couples experiencing fertility problems.

However, the ART journey is far more than a series of medical procedures and success rates. As highlighted by Salerno and Merenda (2016), fertility treatments involve a significant emotional burden, often characterized by intense feelings of sadness, anger, shame, and isolation. The cyclical nature of the treatments, alternating between hope and disappointment, the invasiveness of the procedures, the financial and emotional costs, and the uncertainty of outcomes create a context of chronic stress that can severely challenge individual and relational psychological resources.

In this complex scenario, psychological support plays a crucial role. The guidelines of the Italian Ministry of Health (2024) explicitly acknowledge this need, stating: «Each ART center must provide couples with access to counseling and the possibility of psychological support for patients and couples who require it…». Psychological support is thus not an optional component but an integral part of the care pathway, to be made available throughout all phases of the diagnostic and therapeutic process for infertility.

Among the various forms of psychological support, group

interventions emerge as particularly effective. As noted by Piccinino (2019), group settings offer a unique opportunity for sharing with others undergoing similar experiences, reducing the sense of isolation and normalizing the emotional responses associated with infertility. Engaging with peers who truly understand the challenges of infertility and ART can provide substantial emotional support and foster shared coping strategies.

Within this clinical and theoretical framework, expressive writing is introduced as a promising therapeutic tool. Conceptualized and developed by James W. Pennebaker in the 1980s, expressive writing is based on the principle that writing about deep thoughts and emotions can facilitate the cognitive-emotional processing of difficult or traumatic experiences. In their pioneering 1986 study, Pennebaker and Beall showed that university students who wrote for 15–20 minutes per day over four consecutive days about a personal traumatic experience exhibited better physical and mental health in the following months compared to a control group who wrote about neutral topics (Lo Iacono, 2016).

The mechanisms through which expressive writing exerts its beneficial effects have been widely investigated. Pennebaker (1989; 1997) identified two primary mechanisms: emotional inhibition reduction and cognitive restructuring. The inhibition theory posits that suppressing thoughts and emotions related to traumatic experiences requires constant cognitive effort, leading to stress accumulation and related health issues. Expressive writing, by allowing emotional expression, reduces the cognitive and physiological burden associated with emotional suppression.

Cognitive restructuring, on the other hand, suggests that writing about emotionally intense events compels individuals to organize and make sense of the experience in a structured way. This process facilitates the integration of the event into one's life narrative, thereby reducing the cognitive and emotional fragmentation typical of traumatic or stressful experiences (Barros *et al.*, 2020; De Luca Picione, 2022; De Luca Picione & Valsiner, 2017; Frattaroli, 2006; Freda & Martino, 2015; Freda *et al.*, 2023; Salvatore *et al.*, 2022, 2024; Stenner & De Luca Picione, 2023).

The efficacy of expressive writing has been demonstrated in various clinical contexts, with reported benefits including improved

immune function, reduced medical visits, lower levels of depression and anxiety, and overall improvements in quality of life (Lepore, 1997; Pennebaker, 1997; Pennebaker & Beall, 1986; Pennebaker & Smith, 2017).

In the specific field of ART, research on the application of expressive writing remains relatively limited. Studies conducted in Italy by Renzi and colleagues (2013, 2014, 2017, 2021) have begun to systematically explore the potential of this technique in supporting patients undergoing ART. Findings have indicated improvements in emotional identification and regulation, better cognitive-emotional processing, and in some cases even increased pregnancy rates (Cleves-Valencia *et al.*, 2024; Renzi, 2016).

However, not all studies have yielded unequivocally positive results. For example, Panagopoulou *et al.* (2009) did not find significant differences in emotional distress between experimental and control groups and observed a higher pregnancy rate in the group that did not participate in expressive writing. Similarly, Frederiksen *et al.* (2017) reported a reduction in depressive symptoms but not in anxiety or infertility-related distress, concluding that the efficacy of expressive writing in the context of infertility requires further investigation.

These contrasting findings highlight the complexity of the phenomenon and the need for further research to explore not only whether expressive writing is effective, but also for whom, under what conditions, and through which specific mechanisms. It is particularly important to consider how this technique can be optimally integrated with other forms of psychological support, such as group psychological counseling, to maximize its therapeutic benefits.

The present study is situated within this research context and aims to contribute to the understanding of the effectiveness of expressive writing when integrated into a structured group psychological counseling program for ART patients. The adopted approach combines the benefits of individual expressive writing with those of group support, creating a multidimensional intervention designed to address the complex psychological needs of individuals undergoing assisted reproduction.

Aims

The primary objective of this study was to evaluate the effectiveness of expressive writing as a therapeutic intervention integrated into a group psychological counseling program for patients undergoing Assisted Reproductive Technology (ART) treatments. The research aimed to explore the potential of this combined approach in promoting emotional processing and reducing the psychophysical stress burden commonly associated with ART journey.

Specifically, the investigation aimed to verify the impact of the integrated intervention on three core dimensions: the reduction of depression levels, the improvement in emotional regulation, and the enhancement of perceived quality of life. An additional objective was to explore the potential positive effects of the intervention on couple dynamics, investigating whether the integration of individual processing through writing and group support could foster greater cohesion, communication, and mutual understanding throughout the ART process.

The central hypothesis of the study posited that the integrated intervention, combining expressive writing, which stimulates deep emotional and cognitive processing of the ART experience, with group psychological counseling, which provides emotional validation, normalization of experiences, and reduction of isolation, could significantly contribute to reducing psychophysical distress and enhancing emotional resilience. The study therefore aimed to provide empirical evidence of the usefulness of this intervention model within psychological support protocols for ART patients, contributing to the development of more effective and personalized therapeutic approaches.

Method

Study Design

This study employed a quasi-experimental design with pre- and post-intervention assessment without a control group. This methodological choice was informed by both practical and contextual considerations inherent to the clinical setting. The limited number of

participants and the characteristics of the convenience sample did not allow for the creation of a separate control group.

Although the pre-post design has inherent limitations, it allowed for the evaluation of changes in participants by comparing measurements taken before and after the intervention. This approach, commonly adopted in clinical research conducted in real-world settings, yields valuable insights into intervention effectiveness, although causal interpretations should be made with caution.

Setting and Context

The study was conducted at an Assisted Reproductive Technology center within a public healthcare facility in Northern Italy, recognized as a reference center at both local and national levels. The center, supported by a non-profit association founded by former patients, promotes an integrated approach to ART that values both the medical and psychological dimensions of care.

The decision to conduct the study in this particular setting was based on several factors: first, the established collaboration between the medical center and the association facilitated the implementation of the psychological intervention; second, the sensitivity of the head physician and the medical team to the psychological aspects of ART created a favorable environment for integrating psychological support into the treatment process. Finally, the ability to offer sessions both in-person and online enabled the inclusion of patients from various regions across Italy, increasing the sample's representativeness. All participants, however, opted for the online format, and the sessions were therefore conducted synchronously via remote connection, with all group members participating simultaneously.

The Intervention: "Storie di PMA" ("ART Stories") Program

The intervention, titled "*Storie di PMA*" ("ART Stories"), consisted of a group psychological counseling program integrating the technique of expressive writing, that lasted seven months, from November 2023 to May 2024. The structure included monthly group sessions of

approximately two hours each, for a total of seven meetings. The sessions were conducted by a psychologist. Healthcare professionals from the Assisted Reproductive Technology Center did not directly participate in the sessions, in order to ensure a psychological processing space distinct from the medical setting and to promote the free emotional expression of participants, including potential difficulties or ambivalences toward the treatment itself.

During the first session, participants were introduced to the group counseling program and the research project, with an explanation of expressive writing and a detailed presentation of the objectives, procedures and confidentiality rules. At this stage, the pre-intervention assessment instruments were administered, followed by the first writing exercise.

Each session followed a consistent structure consisting of three phases: an initial stage of welcoming and introduction of the theme, an individual writing phase, and a subsequent phase of group sharing and reflection. Participants spent approximately twenty minutes on expressive writing, following Pennebaker's protocol, which invites individuals to write continuously about their deepest thoughts and feelings related to the proposed topics, without concern for grammar, spelling, or structure (Pennebaker & Beall, 1986). Writing took place simultaneously, with cameras turned off to promote focus and privacy.

At the end of the writing phase, participants who wished to do so could share reflections, emotions, or excerpts from their texts with the group, in a non-judgmental environment aimed at emotional elaboration and the construction of shared meanings. This structure allowed for the integration of the benefits of expressive writing, facilitation of emotional processing, reduction of inhibition, and cognitive restructuring (Pennebaker, 1997), with those of group work, such as reduction of isolation, validation of experiences and vicarious learning (Piccinino, 2019).

The writing themes were selected to guide participants through a progressive emotional exploration process, moving from the narration of their experience and the emotions associated with infertility and ART, to relational dimensions and experiences of loss, and finally to a projection of the self into the future (see Table 1).

Table 1 – *Writing themes*

Session	Theme	Objective
1	The story of one's infertility	Narrative reconstruction of the experience
2	Emotions related to infertility/ART	Exploration of emotional experience
3	Letter to one's partner	Facilitation of couple communication
4	Free topic	Emergence of personally significant themes
5	Loss and grief	Processing of losses experienced in the context of infertility
6	Sharing and taboos	Exploration of the relationship with the social context
7	Letter from the future to oneself	Positive projection and closure

This sequence facilitated a progressive integration of the experience, fostering reflection and personal growth.

The seventh and final session concluded with a collective reflection, during which participants shared the insights gained and the resources developed to face future challenges, thereby strengthening mutual support beyond the structured sessions. At the end of the program, the post-intervention assessment instruments were administered again.

The decision to propose a progressive thematic pathway, instead of the original Pennebaker protocol, which invites participants to write about the most traumatic experience of their life, was motivated by specific clinical and methodological considerations related to the ART context. The experience of infertility does not constitute a single traumatic event, but rather a complex process involving identity, relational, bodily, and social dimensions (Molina *et al.*, 2025; Salvatore *et al.*, 2025). Structuring the intervention around themes, therefore, allowed for a gradual emotional exploration, facilitating access to emotions even for participants with no prior psychological support experience, and enhancing group cohesion through a shared focus.

Measures

The evaluation of the intervention's effectiveness was based on a multidimensional approach that integrated four primary instruments, selected for their ability to capture the various aspects of participants' psychological and relational well-being.

The Fertility Quality of Life Questionnaire (FertiQoL), in its Italian validated version by Volpini *et al.* (2020), was employed as a fertility-specific measure of quality of life.

The instrument consists of 36 items divided into two modules: Core and Treatment.
- The Core module includes 2 optional items assessing overall quality of life and physical health, and 24 items grouped into four sub-scales (Boivin *et al.*, 2011):
  • Emotional: explores the emotional impact of infertility.
  • Mind-Body: evaluates the influence of infertility on physical and mental well-being.
  • Relational: examines the impact of infertility on the couple's relationship and overall quality of life.
  • Social: assesses the impact of infertility on social and professional relationships.
- The Treatment module contains 10 items organized into two sub-scales:
  • Environment: evaluates satisfaction with the healthcare environment.
  • Tolerability: explores the physical and emotional tolerability of the treatment.

Each item is rated on a 5-point Likert scale, with standardized scores ranging from 0 to 100, where higher scores indicate better quality of life (Boivin, 2011).

The Difficulties in Emotion Regulation Scale-20 (DERS-20), in its Italian short version validated by Lausi *et al.* (2020), was used to assess emotion regulation difficulties across five dimensions:
1. Non-acceptance of negative emotional responses.
2. Difficulty controlling impulsive behaviors when emotionally activated.

3. Lack of emotional awareness.
4. Lack of emotional clarity.
5. Difficulty engaging in goal-directed behavior when emotionally activated.

The short version maintains sound psychometric properties compared to the original version and is particularly suitable for clinical research contexts (Lausi *et al.*, 2020).

The Teate Depression Inventory (TDI) was selected as the specific tool for assessing depressive symptoms due to its excellent psychometric properties within the Italian population and its sensitivity in detecting sub-threshold symptoms, which are especially relevant in the context of ART (Balsamo & Saggino, 2013). The TDI consists of 21 items based on the diagnostic criteria for Major Depressive Episode (DSM IV-TR and V), exploring affective, cognitive, physical, and behavioral symptoms through a 5-point Likert scale.

A specifically designed *sociodemographic questionnaire* completed the assessment battery, collecting information on age, sex, marital status, education level, occupation, duration of the relationship, length of time attempting to conceive, and previous requests for psychological support. These data allowed for a detailed characterization of the sample and the exploration of potential moderating variables related to intervention effectiveness.

Participants

Sample characteristics. The final study sample consisted of 11 participants (5 couples and one individual participant) recruited from the patient population at the ART center, who voluntarily enrolled in the group psychological counseling program. This was a convenience, non-randomized sample, with inclusion criteria based on being actively engaged in ART treatment and availability to participate in the full intervention cycle. The sample reflects the clinical reality of the service and the typical characteristics of the population accessing ART treatment in Italy.

Socio-demographic characteristics. Participants' ages (see Table 2) showed a considerable range, extending from 31 to 55 years, reflecting the phenomenon of delayed parenthood that characterizes contemporary society.

Table 2 – *Age*

Age	Frequencies	% of Total	Cumulative %
31-35	2	18.2%	18.2%
36–40	5	45.5%	63.6%
41–45	3	27.3%	90.9%
51–55	1	9.1%	100.0%

The highest concentration of participants fell within the 36–40 age range (45.5%), aligning with national data indicating that the average age of women accessing ART in Italy is approximately 37 years.

Gender distribution was relatively balanced, with 6 women (54.5%) and 5 men (45.5%), reflecting the presence of complete couples in the group. This gender balance represents a strength of the study, considering that much infertility research tends to focus predominantly on female populations.

Regarding marital status, the sample was nearly evenly split between married individuals (5 participants, 45.5%) and cohabiting partners (6 participants, 54.5%). Relationship duration (see Table 3) showed substantial stability, ranging from a minimum of 5 years to a maximum of 14 years.

Table 3 – *Relationship/cohabitation duration*

Duration (years)	Frequencies	% of Total	Cumulative %
5	3	27.3%	27.3%
6	2	18.2%	45.5%
7	2	18.2%	63.6%
12	2	18.2%	81.8%
14	2	18.2%	100.0%

None of the participants had children at the time of the study.

The educational level of the sample was medium to high, with 4 participants holding a university degree and 3 possessing postgraduate qualifications. The occupational profiles were diverse, with a predominance of employees and teachers.

A central variable for understanding the sample was the duration of the attempt to conceive (see Table 4), which varied considerably among participants. This variability reflects the prolonged stress and emotional burden experienced by couples prior to joining the group.

Table 4 – Conception attempt duration

Duration (years)	Frequencies	% of Total	Cumulative %
3	5	45.5%	45.5%
6	2	18.2%	63.6%
2	2	18.2%	81.8%
5	2	18.2%	100.0%

Particularly noteworthy was the data regarding prior access to psychological support: only 3 out of 11 participants had previously sought psychological help for infertility-related difficulties. These help-seeking episodes occurred at different stages: one participant began psychological treatment after learning she would need to undergo heterologous fertilization and was still receiving support at the time of the study; another initiated counseling at the beginning of the ART process; and a third participant requested a psychological evaluation approximately four months before the initial questionnaire was administered.

Despite its small size, the sample presents characteristics that make it reasonably representative of the population accessing ART services in Italy: advanced maternal age, high educational attainment, stable relationships, and prolonged histories of infertility.

Figure 1 – Participant flow diagram
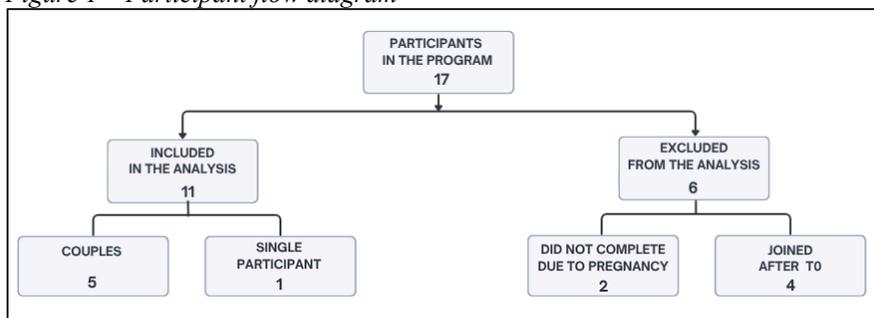
The presence of five complete couples in the sample represents a particularly interesting aspect of the study. Both partners in these couples actively participated in all sessions, sharing the same group space while producing independent individual writings. This configuration made it possible to observe, albeit within the limits of the quantitative analysis conducted, how the intervention could influence both the individual well-being of each partner and, potentially, the couple's dynamic through the sharing of a common elaborative experience. The single participant was a woman whose partner was unable to take part in the group.

It is important to note that the number of participants would have been higher, but not all individuals completed the full intervention. Some participants left the program due to a successful pregnancy, while others joined the group after the initial round of assessment had already taken place (see Figure 1).

Reasons for exclusion:

- Pregnancy achieved: two participants, a couple, achieved a pregnancy during the program and chose to discontinue their participation in the group. Although this represents a positive outcome, it prevented the completion of the full pre–post assessment.
- Late entry: four participants joined the group after the initial test administration (T0) had already taken place, making pre–post comparison impossible. These participants nevertheless benefited from the intervention but were not included in the quantitative analysis.

It is important to note that there were no actual dropouts due to dissatisfaction or difficulties related to the intervention, indicating good overall acceptability of the proposed program.

The management of these moments required careful clinical attention. This dynamic, typical of open groups in clinical settings, introduced certain limitations in pre-and post-data collection for the entire sample, which is why those cases were excluded from the study.

Qualitative characteristics of the sample. In addition to quantitative data, several qualitative observations help complete the description of the sample:

1. Motivation to participate: participants generally exhibited high motivation, as evidenced by regular attendance.

2. Emotional openness: emotional openness varied initially, with some participants more reserved. However, this openness generally increased over the course of the group sessions.
3. Engagement with writing: adherence to the expressive writing task was generally positive, with most participants demonstrating good willingness and engagement in the activity. One participant, however, experienced greater difficulty approaching the writing exercises and required additional encouragement and extended time to complete the proposed tasks, although they remained engaged in the group process.
4. Personal resources: overall, participants demonstrated good personal resources in terms of reflective capacity, social support (beyond the partner), and coping strategies, despite some individual variability.

Ethical approval for the study was obtained from the hospital's Medical Director, the Head Physician and the non-profit association. All procedures performed in the study were in accordance with institutional ethical standards and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. Participants were informed about the general aim of the research, the anonymity of responses, and the voluntary nature of participation, and they signed an informed consent form. No incentive was given.

Data analysis

The effectiveness of the intervention was assessed through the analysis of pre-and post-treatment score variations on the administered scales. For the FertiQoL, in addition to the total score, three specific subscales were analyzed separately: the Core scale (assessing emotional and social aspects central to quality of life), the Treatment scale (measuring satisfaction with medical treatment), and the Relational scale (examining the impact of infertility on interpersonal relationships). For the DERS-20 and TDI, total scores were analyzed.

Given the nature of the sample and the measures used, statistical analysis was conducted using the Wilcoxon signed-rank test for paired samples, implemented in the Jamovi software. The choice of this non-parametric test was based on several methodological considerations:

1. Sample size: with a small final sample, parametric tests such as the paired-samples t-test would have yielded less reliable estimates. The Wilcoxon test retains robust statistical properties even with small samples, without compromising result validity (Blair & Higgins, 1985).
2. Distributional assumptions: the limited sample size could have led to violations of the normality assumption required for parametric tests. The Wilcoxon test, which does not require assumptions about distributional shape, was therefore more appropriate (Chiorri, 2010).
3. Nature of the data: the psychometric scales used produce ordinal or interval-level data, for which the Wilcoxon test is particularly suitable, as it is based on ranks rather than absolute values (Pappas & DePuy, 2004; Chiorri, 2010).
4. Repeated-measures design: since the same participants were assessed pre-and post-intervention, a test accounting for the dependency between observations (paired samples) was required. The Wilcoxon test is ideal in this context, as it evaluates within-subject differences (Blair & Higgins, 1985; Pappas & DePuy, 2004).

Results

Data analysis revealed differentiated patterns of intervention effectiveness across the evaluated dimensions.

Fertility-related quality of life (FertiQoL)

The analysis of quality of life through the FertiQoL showed varied results across the different subscales, highlighting areas of significant improvement alongside domains that did not exhibit substantial changes.

The Core subscale (see Table 5) showed a statistically significant improvement ($p = 0.009$, well below the 0.05 threshold), with a large effect size ($r = 0.818$) indicating a substantial increase in participants' emotional and social well-being.

Table 5 – *Wilcoxon Signed-Rank Test for Paired Samples–FertiQoL-Core*

			Statistics	p		Effect size (r absolute value)
SUM_Q_pre	SUM_Q_post	Wilcoxon W	6.00	0.009	Rank-bi-serial cor-relation	0.818

Note. SUM_Q_pre = FertiQoL-Core sum scale pre-intervention. SUM_Q_post = FertiQoL-Core sum scale post-intervention.

The Treatment subscale, which measures satisfaction with medical treatment, showed no significant difference (see Table 6): the *p*-value was 0.837, well above the 0.05 threshold, with a medium effect size ($r = 0.318$). This suggests that the perception of medical treatment remained essentially stable, without clinically relevant changes.

Table 6 – *Wilcoxon Signed-Rank Test for Paired Samples – FertiQoL-Treatment*

			Statistics	p		Effect size (r absolute value)
SUM_T_pre	SUM_T_post	Wilcoxon W	43.5	0.837	Rank-biserial correla-tion	0.318

Note. SUM_T_pre = FertiQoL-Treatment sum scale pre-intervention. SUM_T_post = FertiQoL-Treatment sum scale post-intervention.

Similarly, the Relational subscale (see Table 7), assessing the impact of infertility on interpersonal relationships, showed no significant change ($p = 0.141$). The *p*-value of 0.141, also exceeding the 0.05 threshold, suggests that the intervention had no meaningful effect on this dimension. However, the medium effect size ($r = 0.422$) suggests a trend toward improvement in couple relationship quality, although not sufficiently pronounced to reach statistical significance.

Table 7 – *Wilcoxon Signed-Rank Test for Paired Samples – FertiQoL-Relational*

			Statistics	p		Effect size (r absolute value)
SUM_rel_pre	SUM_rel_post	Wilcoxon W	13.0	0.141	Rank-bi-serial correla-tion	0.422

Note. SUM_rel_pre = FertiQoL-Relational sum scale pre-intervention. SUM_rel_post = FertiQoL-Relational sum scale post-intervention.

Finally, the FertiQoL total score (see Table 8) showed a statistically significant improvement ($p = 0.046$), with a large effect size ($r = 0.591$), indicating an overall positive effect of the intervention on quality of life.

Table 8 – *Wilcoxon Signed-Rank Test for Paired Samples – FertiQoL -Total*

			Statistics	p		Effect size (r absolute value)
SUM_Qol _tot_pre	SUM_Qo l_tot_post	Wilcoxon W	13.5	0.046	Rank-bi-serial cor-relation	0.591

Note. SUM_Qol_tot_pre = FertiQoL-Total sum scale pre-intervention. SUM_Qol_tot_post = FertiQoL-Total sum scale post-intervention.

Emotional regulation (DERS-20)

The assessment of emotion regulation through the DERS-20 (see Table 9) showed a significant improvement ($p = 0.041$), with a large effect size ($r = 0.636$). This result highlights a substantial enhancement in the participants' emotion regulation abilities, in line with the objectives of the integrated intervention program.

Table 9 – *Wilcoxon Signed-Rank Test for Paired Samples – DERS-20*

			Statistics	p		Effect size (r absolute value)
SUM_DERS-20_tot_pre	SUM_DERS-20_tot_post	Wil-coxon W	45.0	0.041	Rank-bi-serial cor-relation	0.636

Note. SUM_DERS-20_tot_pre = DERS-20 sum scale pre-intervention. SUM_DERS-20_tot_post = DERS-20 sum scale post-intervention.

Depressive symptoms (TDI)

Regarding depressive symptoms assessed with the TDI (see Table 10), the results showed a trend toward improvement that approached statistical significance ($p = 0.055$), with a large effect size ($r = 0.561$). This finding suggests a tendency toward a reduction in perceived depressive mood at the end of the program.

			Statistics	p		Effect size (r absolute value)
SUM_TDI _tot_pre	SUM_TDI _tot_post	Wilcoxon W	51.5	0.055	Rank-bi-serial cor-relation	0.561

Note. SUM_TDI_tot_pre = TDI sum scale pre-intervention. SUM_TDI_tot post = TDI sum scale post-intervention.

In addition to statistical significance, the effect size was calculated for each analysis using Rosenthal's *r*, which is appropriate for the Wilcoxon test. According to Cohen's (1988) conventions, *r* values of 0.10 indicate a small effect, 0.30 a medium effect, and 0.50 a large effect. This measure allows for the evaluation not only of whether a statistically significant difference occurred, but also of the practical and clinical relevance of the observed change (Chiorri, 2010).

Discussion

The findings from this study offer important insights into the effectiveness of an integrated group counseling intervention combined with expressive writing within the specific context of ART. The significant improvements observed in core quality of life and emotion regulation confirm the therapeutic potential of this approach, in line with previous studies employing expressive writing in different modalities (Frederiksen *et al.*, 2017; Renzi *et al.*, 2013). The present study extends this evidence by demonstrating that the integration of expressive writing into group psychological counseling can produce substantial benefits across these domains.

However, it is important to note that the study design does not allow for a clear distinction between the specific contributions of expressive writing and those of group support, and that the observed outcomes could be attributed to the synergistic effect of both components of the intervention. Both components, individual expressive writing and group psychological counseling, operate through complementary mechanisms. On the one hand, expressive writing allows patients to externalize their emotions and concerns related to fertility, which are

often intense and difficult to verbalize. This can reduce anxiety and stress associated with fertility problems, thereby improving perceived quality of life (Renzi & Solano, 2015; Renzi *et al.*, 2013; Renzi *et al.*, 2014; Renzi *et al.*, 2017; Renzi *et al.*, 2021). On the other hand, the group setting may further enhance emotional support among participants, reducing feelings of isolation and reinforcing the therapeutic effect (Piccinino, 2019). In the context of ART, where emotions are often intense and conflicted, the opportunity to express them in written form offers a safe space for exploring and integrating difficult experiences.

The improvement in emotional regulation is particularly relevant, considering that ART treatments demand a significant capacity to manage stress and emotional fluctuations linked to cycles of hope and disappointment. This result may have important practical implications for the ART journey: improved emotional regulation may foster greater adherence to treatment and more effective communication with the medical team. Regarding couple conflict and medical outcomes, the data from the present study do not allow for firm conclusions, as the relational dimension did not show significant changes and no information was collected on treatment results. However, existing literature suggests that psychological interventions effective in reducing stress may also have a potentially positive influence on reproductive outcomes (Frederiksen *et al.*, 2017), an aspect that warrants further investigation in future studies.

The absence of significant effects on the perception of medical treatment may be interpreted considering the complexity of factors influencing this dimension. The relationship with the medical team, past experiences of therapeutic failure, and individual expectations are deeply rooted elements that are unlikely to be modified by a short-term psychological intervention. Previous research has shown that couples who have experienced treatment failures, as in the present sample, report increasing concerns about treatment timelines (Martinelli & La Sala, 2009). Moreover, success in fertility treatment is not limited to technical outcomes but also depends on clinicians' ability to recognize and address patients' emotional and psychological needs. The quality of the doctor-patient relationship affects both treatment outcomes and patients' overall well-being (Kelley *et al.*, 2014). Repeated failures, if not managed relationally, can lead patients to

develop critical attitudes toward clinics and adjust their expectations about future treatments (Dancet *et al.*, 2010; Klitzman, 2018).

This result suggests the need for more targeted approaches, possibly integrated with interventions aimed at improving doctor-patient communication.

Similarly, the lack of significant improvement in the relational dimension calls for further reflection: couple dynamics in the context of infertility are profoundly complex, involving deep identity issues, dynamics of guilt and responsibility, and the renegotiation of roles and shared life plans that have developed over time. As noted by Riccio (2017), infertility challenges the couple's "dyadic membrane", requiring adaptive processes that may need more specific and extended interventions. Infertility and its treatment can trigger relational difficulties as couples adjust to a highly stressful condition (Peterson *et al.*, 2003). The established balance between partners may be disrupted, leading to dissatisfaction, anxiety, and sexual problems (Riccio, 2017). While expressive writing and psychological counseling may support individual emotional processing, they may not have an immediate or direct impact on couple dynamics. Relationship changes often require more targeted and prolonged interventions, such as couples therapy.

The trend toward improvement in depressive symptoms, although not statistically significant, warrants attention. Depression in the context of ART is often characterized by subthreshold manifestations that can still significantly affect quality of life. The fact that the intervention showed a positive, albeit limited, effect suggests that expressive writing, when integrated into a psychological counseling program, may contribute to preventing symptom worsening, acting as a protective factor.

A crucial aspect that emerged from the study concerns the importance of the group context. The sharing of writings and experiences created a space of emotional resonance where participants could feel understood and less alone in their journey.

Limitations and future directions

Despite the promising results, this study presents several limitations that reduce the generalizability and robustness of the findings and must be considered when interpreting the results, and that, at the same time, suggest directions for future research.

First, the absence of a control group represents a significant limitation, as it prevents the attribution of the observed changes solely to the proposed intervention rather than to external factors such as the mere passage of time, placebo effects, or concurrent life events (Chiorri, 2010). This methodological choice was primarily driven by practical and contextual constraints inherent to the clinical setting, including the limited number of participants, which did not allow for the creation of a separate control group. Closely related to this limitation is the inability to distinguish the specific contributions of expressive writing from those of group counseling. The lack of a control group that participated only in group counseling without expressive writing, or vice versa, limits the ability to attribute the observed changes exclusively to one of the two components. Future studies could adopt more robust research designs, such as implementing wait-list control groups or factorial designs comparing individual expressive writing, group counseling alone, the combined intervention, and a control group. Such approaches would allow for the assessment of both the main effects of each component and their possible interaction effects, while still ensuring that all patients have access to the intervention.

Second, the small sample size limits the statistical power of the analysis, increasing the likelihood of not detecting significant differences in some of the scales used, such as the TDI and certain FertiQol subscales. A larger sample could yield more robust results and offer greater sensitivity in detecting even subtle effects (Chiorri, 2010; Renzi *et al.*, 2021). Additionally, the sample was not selected using a systematic sampling method, which may impact the generalizability of the results and also introduces potential selection biases. It is possible that these patients exhibited specific characteristics, such as greater psychological openness, enhanced reflective capacities, and higher motivation for change, that distinguish them from the general ART population, potentially limiting the generalizability of the findings to less motivated patients or those with greater difficulties in emotional

processing. However, the analysis still provides valuable insights into the experiences of ART patients, particularly when integrated with socio-demographic and infertility history data.

Furthermore, the heterogeneity of the sample with respect to the stage of treatment (from first attempts to multiple failures) introduces variability that may obscure differential effects and future studies could benefit from more stringent inclusion criteria or stratified analyses. A potential direction for future research would be to investigate whether the intervention produces different effects in patients who have just begun ART and those who have been undergoing treatment for several years, particularly in the context of repeated failures. Such an analysis would allow exploration of how the duration of treatment and experiences of failure may influence psychological well-being, emotion regulation, and quality of life. Patients undergoing treatment over a longer period may exhibit higher levels of stress, anxiety, and frustration compared to those in the initial phases, which may require specific and targeted psychological interventions.

Additionally, psychological measures could be used to monitor long-term emotional adjustment and potential differences in coping between patients with recent versus long-term ART experiences. This distinction could help in developing more personalized interventions, with support programs tailored according to the stage of treatment and patients' lived experiences.

Another possible limitation of this research concerns the self-reported nature of the measures, based on questionnaires such as the FertiQol, DERS-20, and TDI, may introduce subjective and social desirability bias, as participants' responses could be influenced by emotional states or the desire to present themselves in a favorable light (Chiorri, 2010).

The wide interval between writing sessions, one month, represents a significant deviation from Pennebaker's original protocol, which involves daily or closely spaced sessions. Although this choice was guided by practical and clinical considerations, allowing for group processing and integration of contents between sessions, it is possible that shorter intervals might have produced more pronounced effects. According to Pennebaker (1997; Pennebaker & Smyth, 2017), participants benefit more from multiple writing sessions spaced a few days apart rather than a single session. Pennebaker hypothesized that

repeated writing allows for deeper emotional processing, giving the brain time to assimilate thoughts and better cope with accumulated emotional stress. While this hypothesis is intriguing, the literature supporting it is still limited, and further studies are needed to confirm whether repeated and spaced sessions produce significantly better outcomes than a single session.

Even the lack of a formal qualitative analysis of the written texts represents a missed opportunity; a thematic analysis of the writings could reveal mechanisms of change not captured by quantitative measures. Methods such as thematic analysis (Braun & Clarke, 2006) or computerized linguistic analysis could effectively complement quantitative data in future studies.

In terms of future perspectives, another area that could be further explored concerns the FertiQol subscales that did not show significant improvement, such as the Treatment and Relational scales. Future interventions could investigate whether the effectiveness of the intervention might be enhanced by combining it with additional tools that specifically address patients' perceptions of medical treatments and their impact on interpersonal relationships.

Further research could explore the social dimensions of couples undergoing ART, examining whether their relationships serve as a resource or not. This could be investigated using the Social subscale of the FertiQol or other appropriate tools to assess social support and the impact of interpersonal relationships in the context of ART. Research by Martins and colleagues (2011), for instance, examined the relationship between family support, coping, and infertility-related stress, showing that perceived family support can significantly affect how women experience infertility-related stress, both directly and indirectly.

Despite these limitations, the study provides important preliminary evidence on the usefulness of combined intervention of expressive writing and group psychological counseling in psychological support to ART patients, opening several avenues for future research aimed at optimizing this therapeutic approach and identifying the conditions under which it proves most effective.

Conclusion

Significant improvements in quality of life and emotional regulation, along with a positive trend in the reduction of depressive symptoms, suggest that this approach could be a valuable addition to psychological support interventions in this context. And the results suggest several implications for clinical practice in the psychological support of ART patients.

The proposed intervention can be regarded as a low-cost and highly applicable model that could be integrated into standard psychological support protocols within ART centers. Its structure allows for relatively easy implementation even in settings with limited resources: it does not require specific equipment or highly specialized environments, and it can be conducted both in person and online, thereby increasing geographical accessibility.

The results also suggest that this intervention may be effective both for patients who have already undergone several treatment cycles and need to process their accumulated experiences, and for those at the beginning of the ART journey, with a function that is more preventive than elaborative, even though they may already have a history of infertility.

From a clinical perspective, while maintaining a standardized framework, the intervention can be tailored to the specific needs of the participants. Since not all individuals respond equally to this type of intervention, it is important to develop personalized strategies that consider factors such as baseline levels of emotional regulation, personal infertility history and the type of psychological support needed. Expressive writing can be adapted by increasing the number of sessions, which may be conducted either with therapeutic guidance or independently at home.

Furthermore, the group intervention does not replace but rather complements other forms of psychological support. It can be combined with individual therapy, precede or follow couple interventions, facilitating not only individual emotional processing but also fostering group cohesion. This contributes to enhancing the sense of belonging and shared experience (De Luca Picione *et al*. 2025), factors that may further improve patients' quality of life.

The clinical implications of this research also extend beyond direct patient intervention, highlighting the need for specific training for healthcare professionals. Effective implementation requires that

psychologists working in ART settings develop specialized competencies, including an in-depth understanding of Pennebaker's expressive writing protocol and its empirical evidence, skills in conducting psychological groups, with particular attention to managing intense emotions and facilitating sharing within a climate of trust, knowledge of the medical, psychological, and relational aspects of infertility and ART, and sensitivity in identifying situations that require referral to more intensive levels of care.

The systematic integration of this intervention within ART centers requires certain organizational conditions: the availability of suitable spaces for group meetings ensuring privacy and confidentiality; inclusion of the group psychological support offer in the informational materials provided to couples entering ART programs and flexibility in scheduling sessions to encourage participation (e.g., evening or weekend options). Collaboration with associations of former patients, as in the present study, may further facilitate implementation by providing logistical support, contributing to the dissemination of information, and bridging the medical and experiential dimensions of infertility.

The intervention proved particularly effective in facilitating individual emotional processing and enhancing overall psychological well-being, while showing less impact on relational dynamics and perceptions of medical treatment. These differentiated outcomes highlight the importance of integrated approaches that combine various types of interventions to address the complexity of ART patients' psychological needs.

The significance of the group context emerging from this study underscores how the combination of individual processing through writing and group sharing can create particularly effective therapeutic synergies. This intervention model offers patients both the introspective space necessary for personal elaboration and the social support essential for reducing the isolation that often accompanies infertility.

Despite methodological limitations, this study makes a meaningful contribution to the limited literature on expressive writing in the context of ART, particularly within the Italian setting. The findings encourage further research with more robust designs and larger samples but already suggest that this integrated intervention model deserves consideration as a complementary option in the psychological support of patients facing the challenges of assisted reproduction.

The future challenge will be to refine and optimize this approach, integrating it ever more effectively with other evidence-based interventions to offer ART patients psychological support that is not only scientifically grounded but also deeply respectful of the complexity and uniqueness of their experience.

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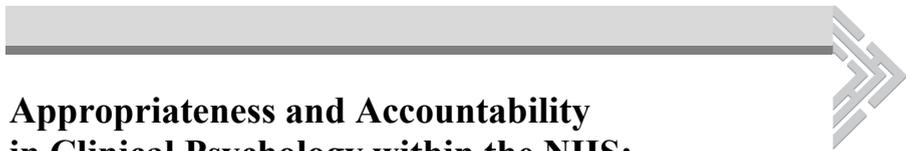
Appropriateness and Accountability in Clinical Psychology within the NHS: Towards a Conceptual Framework

Alessandro Ridolfi, Valentina Panella*, Chiara Ghetti**

Abstract

Clinical psychology within the Italian National Health Service (NHS) is undergoing a structural transition, increasingly required to align with governance principles such as appropriateness and accountability. Yet, these constructs – central to international health policy – have not been systematically articulated within psychological practice. This paper develops a conceptual framework that redefines appropriateness and accountability as intrinsic disciplinary dimensions rather than external administrative requirements. Appropriateness is framed as the alignment of psychological intervention with clinical need, psychosocial context, care pathway positioning, and proportional use of public resources. Accountability is defined as the ability of psychologists to justify decisions, demonstrate outcomes, and contribute to the governance and sustainability of public health services across individual, organisational, and participatory levels.

The framework is situated within current developments in the Italian NHS, including the experimental introduction of the primary care psychologist (psicologo di base), the formal integration of psychologists within multidisciplinary care pathways (PDTA), and the increasing relevance of digital

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data systems and outcome monitoring. A conceptual matrix of appropriateness and a three-phase model of strategic integration are proposed to guide policy, training, and professional practice.

By positioning clinical psychology as a system-based public health discipline, the paper offers a theoretical foundation for enhancing its institutional role, improving coordination across care levels, and supporting value-based and equitable healthcare delivery.

Keywords: National Healthcare Service, appropriateness, accountability, clinical psychology.

Introduction

This paper proposes a conceptual framework through which appropriateness and accountability become strategic foundations for redefining the role of psychology within the governance architecture of the National Health Service (NHS), positioning them as foundational disciplinary dimensions rather than administrative add-ons. Appropriateness is defined as the alignment of psychological interventions with clinical needs, patient readiness, and the proportional use of public resources within coordinated care pathways. Accountability is defined as the capacity of clinical psychology to justify clinical and organisational decisions, demonstrate outcomes in a transparent manner, and assume responsibility towards patients, institutions, and society. These constructs are not treated as administrative constraints, but as foundational disciplinary dimensions that define the institutional legitimacy and public value of clinical psychology within a universal health system. This shift reflects broader governance principles originally developed within the United Kingdom's clinical governance framework (Scally & Donaldson, 1998), which established that healthcare quality is not solely a matter of individual clinical expertise, but a system-wide responsibility grounded in appropriateness, accountability, transparency, and continuous improvement (O'Hagan & Persaud, 2009; Ricciardi & Tarricone, 2021). Within this paradigm, clinical psychology is called to demonstrate not only the effectiveness of its interventions, but also its capacity to participate in governance processes, contribute to integrated care pathways, and ensure the appropriate use of public resources.

In this context, appropriateness and accountability have emerged as central drivers in the evolution of healthcare systems. Appropriateness is defined as the delivery of the right care, to the right patient, at the right time, in the right setting, and with the responsible use of public resources (Scally & Donaldson, 1998; NHS Executive, 1999; WHO, 2000). Accountability refers to the obligation of healthcare professionals and organisations to justify their decisions and demonstrate outcomes transparently to patients, institutions, and society (Denis, 2014; Emanuel & Emanuel, 1996; Fan, 2025; Mulgan, 2000). These concepts underpin value-based healthcare frameworks that aim to optimise health outcomes relative to the resources invested (Gray, 2017; Porter, 2010; Sturmberg & Taher, 2025; Teisberg, Wallace, & O'Hara, 2020) and are increasingly recognised as strategic criteria for evaluating the legitimacy and sustainability of publicly funded services.

Despite their prominence in international health policy, the constructs of appropriateness and accountability have not yet been systematically conceptualised as disciplinary foundations within clinical psychology. Current applications remain largely confined to the evaluation of treatment efficacy and psychotherapeutic outcomes (Leichsenring *et al.*, 2022; Margison *et al.*, 2023), without incorporating broader dimensions such as care coordination, pathway integration, population-level outcomes or the stewardship of public resources (Frank & Shim, 2023; Rosenberg & Salvador-Carulla, 2017). This gap is not merely theoretical: the absence of a unified conceptual model limits the capacity of clinical psychology to demonstrate its institutional mandate within publicly funded health systems and to contribute to the governance and sustainability of healthcare delivery. In the context of emerging challenges, including chronicity, multimorbidity, health inequalities and digital transformation (Castelnuovo *et al.*, 2023; Lombardo, 2023), the development of a coherent framework for appropriateness and accountability becomes essential for defining the public value, institutional legitimacy and strategic positioning of clinical psychology within the NHS. The theoretical and policy gap concerning the institutional role of clinical psychology within universal healthcare systems is addressed through a conceptual framework that repositions appropriateness and accountability as foundational disciplinary dimensions rather than administrative add-ons.

To address this gap, this paper proposes a conceptual framework

that positions appropriateness and accountability as core organising principles of clinical psychology within the NHS, providing a unifying lens through which these constructs can be used to interpret, evaluate, and guide psychological practice within public health systems. The framework draws on existing literature on patient engagement and readiness as core determinants of intervention effectiveness (Graffigna, Barello & Triberti, 2015; Graffigna *et al.*, 2017) and on integrated care pathways as organisational instruments for ensuring continuity, transparency, and measurable outcomes (Allen, Gillen, & Rixson, 2009; Pfadenhauer *et al.*, 2017; Rebecchi, 2018). Through this lens, clinical psychology is positioned not only as a therapeutic discipline, but as a strategic actor in the governance and sustainability of the NHS (Castelnuovo *et al.*, 2016).

Clinical Psychology in the Italian NHS: Organisational Context

Understanding the specific organisational configuration of clinical psychology within the Italian NHS is essential to contextualise the application of appropriateness and accountability as disciplinary constructs. Unlike other universal healthcare systems, the Italian NHS presents a high degree of regional variability and a fragmented institutional positioning of psychological services, which directly affects their capacity to participate in governance processes and to be evaluated according to system-wide criteria.

The Italian NHS is a universalistic public system established in 1978 to guarantee equitable access to healthcare funded through general taxation. It is regionally structured, with national legislation defining the Essential Levels of Care (ELC, *Livelli Essenziali di Assistenza – LEA*) and Clinical Care Pathways (CCP, *Percorsi Diagnostico-Terapeutico-Assistenziali – PDTA*), while regional authorities are responsible for the organisation and provision of services (Ricciardi & Tarricone, 2021). Within this governance framework, psychological services are distributed across multiple care settings but lack a unified institutional structure compared with other health professions such as medicine or nursing, resulting in variability in role definition and institutional visibility (Ridolfi, 20024a).

Clinical psychologists employed within the NHS currently operate

across four principal functional areas. In mental health departments *(which in some regions also include addiction services)*, they contribute to assessment, psychotherapy, rehabilitation and community-based interventions. In hospital settings—particularly in oncology, cardiology, neurology, paediatrics and pain management—psychologists address emotional adaptation to illness, patient adherence to treatment and psychosomatic conditions. In primary care and community services, including family counselling centres and prevention programmes, psychologists provide early interventions, health promotion and support for vulnerable populations. In addition, clinical psychologists are increasingly involved in emergency and disaster response, psychological crisis intervention and public health emergencies, reflecting a growing recognition of their strategic role in population mental health management. Finally, in occupational and organisational healthcare services, they contribute to the well-being of healthcare personnel, prevention of burnout and organisational development. These diverse areas of practice demonstrate that clinical psychology operates as a cross-cutting discipline within the NHS, whose functions are not limited to specific diagnostic sectors but extend across multiple levels of care and organisational settings. Despite their wide distribution across care settings, psychologists often lack formal organisational autonomy. Unlike other health professions, psychology does not typically have a dedicated department within regional health structures. This results in fragmented service provision, limited participation in strategic planning and reduced influence in governance processes (Castelnuovo, 2021; Wiktorowicz *et al.*, 2020). These structural limitations affect the visibility and accountability of psychological services within the system and hinder the full realisation of their potential contribution to population health and service sustainability.

Recent policy developments associated with the territorial reorganisation introduced under the National Recovery and Resilience Plan (PNRR) and formalised through Law Decree No. 77/2021 have led several Italian regions to initiate the implementation of the primary care psychologist model, positioning it as the first psychological access point within community healthcare. This role, while subject to regional variation, is closely integrated with general medical services and provides early assessment, brief interventions and health promotion activities aimed at identifying psychological needs at an early

stage. The strategic rationale of this reform does not lie merely in the introduction of a new professional figure, but in the creation of a structured two-tier psychological care system within the Italian NHS. The primary care psychologist represents the first level of intervention, designed to manage low-intensity or emerging psychological needs, while ensuring that only cases requiring more complex or specialised care are referred to second-level services.

This model explicitly integrates the primary care psychologist with the role of the senior clinical psychologist (dirigente psicologo) employed within specialist NHS settings. The senior clinical psychologist exercises clinical and organisational responsibility, leads multidisciplinary teams, and governs CCP. Within this tiered system, referrals from primary care psychologists to specialist clinical psychologists are regulated through defined criteria, shared documentation standards and accountability mechanisms aimed at ensuring appropriateness, continuity of care and optimal allocation of resources. Thus, the introduction of the primary care psychologist should be understood not as a decentralised or parallel service, but as the first level of a coordinated psychological care architecture, where effectiveness depends on the functional linkage and governance between territorial primary care and specialist psychological services within the NHS.

According to national health data, only 5,215 psychologists were employed within the NHS as of 2022, of whom just over 2,000 worked in mental health services (Ministero della Salute, 2023; 2024). This corresponds to approximately eight psychologists per 100,000 inhabitants, a markedly lower figure than that observed in other European countries. Public-sector ratios in countries such as the United Kingdom, the Netherlands and Norway range from 20 to 30 psychologists per 100,000 inhabitants (OECD, 2023; NHS Digital, 2023). To contextualise this disparity, Table 1 presents comparative data on psychologists employed in the public sector, together with indicators of institutional integration and models of service delivery. As an illustrative example, in the United Kingdom the integration of psychological services is supported by the Improving Access to Psychological Therapies (IAPT) programme, a nationally implemented stepped-care model in which interventions are stratified according to severity and systematically monitored through outcome metrics as part of NHS accountability requirements.

Table 1 – Public Psychologists per 100,000 Residents in Selected European Countries

Country	Psychologists employed in the public sector (per 100,000 population)	Structural integration	Primary model of delivery
Italy	8	Fragmented, regionally variable	Predominantly clinical-therapeutic
United Kingdom	22	Strong integration through NHS pathways	Stepped-care / IAPT
Netherlands	25	Integrated in primary and chronic care	Network-based, prevention-oriented
Norway	30	High integration with clinical autonomy	Universal public model

Sources: Author's elaboration based on OECD Health Data (2023); NHS Digital (2022–2023); Ministero della Salute (2023; 2024); European Observatory on Health Systems.

This structural underrepresentation has significantly impacted the functioning and strategic positioning of psychological services. It has limited access to care within essential service levels, contributed to fragmented delivery across settings and reduced the capacity of the NHS to integrate psychological expertise into multidisciplinary care pathways. These systemic limitations underscore the urgency of developing a conceptual and operational framework that can clearly articulate how clinical psychology is aligned with the governance principles of appropriateness and accountability, contributing to the quality, sustainability and strategic evolution of the NHS.

Appropriateness in Clinical Psychology

This section sets out a discipline-specific definition of appropriateness in clinical psychology, constructed from a synthesis of international frameworks on clinical governance, patient engagement and complex care processes. Rather than reproducing medical criteria, the proposed model reinterprets appropriateness as a multidimensional construct inherent to the psychological discipline, integrating clinical treatability, contextual relevance, pathway coherence and proportionality in the use of public resources.

In clinical psychology, appropriateness refers not simply to matching an intervention to a diagnosis, but to aligning its intensity, timing and modality with the individual's psychological readiness, level of functioning and capacity for engagement within a coordinated care process. This distinguishes psychological appropriateness from traditional medical interpretations, which are primarily procedure-based and diagnosis-driven (Merlo, 2024; Ridolfi, 2024a).

The construct of appropriateness originates within clinical governance frameworks in medicine, where it has been defined as the provision of care that is evidence-based, proportionate and timely within publicly funded systems (Scally & Donaldson, 1998; NHS Executive, 1999). In the Italian NHS, appropriateness has been institutionalised through the ELC, which establish criteria for access to public services. However, such frameworks do not fully capture the relational, processual and context-dependent nature of psychological interventions, which unfold across time and organisational settings, requiring patient engagement and continuity within multidisciplinary care models (WHO, 2000; Arah *et al.*, 2006).

From a psychological perspective, appropriateness is therefore best understood as the alignment of an intervention with the clinical needs, psychosocial context and stage of care of the individual, delivered in a manner that is timely, proportionate to the level of need, and embedded within a coordinated care pathway. This definition incorporates four interrelated dimensions: clinical treatability, referring to the likelihood that the intervention will generate meaningful improvement; contextual relevance, which concerns alignment with the patient's values, functional status and psychosocial environment; process integration, which denotes coherence with organisational pathways and collaboration among care providers; and proportional allocation of resources, which reflects ethical responsibility in the use of public funds relative to expected outcomes and clinical necessity (Allen, Gillen & Rixson, 2009; Graffigna, Barello & Riva, 2015; Graffigna *et al.*, 2017; Pfadenhauer *et al.*, 2017).

Taken together, these dimensions position appropriateness as a foundational disciplinary principle that regulates the role of clinical psychology within a publicly funded health system. Under this framework, psychological interventions must demonstrate not only their therapeutic efficacy, but also their contextual suitability, process

coherence and contribution to the sustainability and accountability of the NHS.

A Conceptual Matrix for Evaluating Appropriateness

To operationalise these dimensions within the framework of clinical governance, a conceptual matrix is proposed as a heuristic tool. The matrix integrates the dimension of treatability with that of process effectiveness in order to differentiate appropriate interventions, those that are timely, proportionate, targeted and integrated, from inappropriate ones that result in inefficiency, including delayed or non-indicated treatments, fragmented care pathways and suboptimal use of public resources. Rather than prescribing specific procedures, the matrix is intended to support evaluative reasoning in publicly funded services in accordance with the principles of clinical governance (Scally & Donaldson, 1998; WHO, 2000).

The matrix presented below has been developed as an original heuristic model tailored to clinical psychology in the NHS, combining clinical governance principles with the processual and relational dimensions that characterise psychological interventions.

Table 2 – Conceptual Matrix of Appropriateness in Clinical Psychology

Level of Treatability (Entry Condition)	Inappropriate Care (Inefficiency Area)	Appropriate Care (Effectiveness Area)
High treatability	Generic or untimely interventions leading to fragmentation, delays, or underuse of patient potential	Timely, targeted interventions resulting in readiness for discharge or care transition
Low treatability	Non-indicated treatments or continuation of ineffective therapy, leading to waste of resources	Tailored interventions that preserve continuity, improve quality of life, and ensure ethical use of public resources

Authors' conceptual elaboration based on principles of clinical governance and adapted to the discipline of clinical psychology.

Implications for Public Psychological Services

This conceptualisation demonstrates that appropriateness in clinical psychology must be assessed not merely at the level of individual treatment efficacy but within the broader organisational and public health context in which care is delivered. An intervention is appropriate not only when it is clinically effective, but when it is proportionate to need, embedded in a coordinated care process and capable of supporting safe transitions between levels of care. Appropriateness thus becomes a criterion that links clinical decision-making to public health objectives, service sustainability and accountability to citizens. This frequently reflects a shift from traditional models of psychology focused primarily on individual therapeutic outcomes to a system-oriented model, in which psychological interventions contribute to the coherence, equity and value of care pathways within the NHS.

Accountability in Clinical Psychology

Accountability represents a core disciplinary construct that defines the institutional role of clinical psychology within publicly funded health systems. It encompasses ethical, organisational and participatory responsibilities that extend beyond clinical practice and shape the contribution of psychologists to the governance of care pathways. Accountability can therefore be examined across three interrelated dimensions.

Accountability as a Foundational Disciplinary Construct

Accountability is recognised as a foundational principle in contemporary healthcare governance, reflecting the ethical, organisational and political expectation that professionals and institutions must justify their actions, demonstrate the outcomes of their interventions and ensure transparency to patients, organisations and society (Castelnuovo *et al.*, 2016; Denis, 2014; Emanuel & Emanuel, 1996;). Within a publicly funded health system such as the Italian NHS, accountability extends beyond individual clinical practice to encompass the responsible use of public resources, adherence to quality and safety

standards, participation in collective decision-making processes and alignment with population health objectives (Keepnews & Mitchell, 2003). Despite its relevance, accountability has not yet been systematically conceptualised within the field of clinical psychology, where it is often understood narrowly in terms of professional ethics or clinical outcomes, rather than as a multidimensional construct anchored in public governance frameworks.

The Multidimensional Nature of Accountability

Theoretical contributions have identified multiple dimensions of accountability in healthcare. Emanuel and Emanuel (1996) distinguish four core dimensions: professional accountability, concerning clinical competence and ethical responsibility; organisational accountability, referring to the effective and efficient use of resources within institutions; political accountability, grounded in the obligation of publicly funded services to respond to citizens; and financial accountability, involving the stewardship of public funds. These dimensions have since been expanded to include participatory accountability, which emphasises the active involvement of patients and communities in evaluating services and shaping care pathways (Brinkerhoff, 2004; Levi *et al.* 2018) Mulgan, 2000; Nejatian *et al.*, 2024; Rahman, Kiran & O'Cathain, 2022). In clinical psychology, participatory accountability is closely linked to patient engagement, shared decision-making and transparency, positioning accountability not only as a regulatory expectation but also as a relational and ethical commitment central to care quality and legitimacy (Frank & Shim, 2023; Peteet, Witvliet & Evans, 2022; Ridolfi, 2024b).

Accountability within Organisational Complexity and Care Pathways

Psychological interventions within the NHS are embedded within organisational structures and care pathways that extend beyond individual therapy sessions. As a result, accountability in clinical psychology encompasses not only the delivery of effective treatments but also contributions to service coordination, documentation of outcomes,

adherence to governance standards and participation in multidisciplinary planning and evaluation (Rosenberg & Salvador-Carulla, 2017). In this view, accountability functions simultaneously as an institutional requirement, defining what public systems expect from psychological services, and as a disciplinary value that legitimises the role of psychology within healthcare governance. Within oncology pathways, for instance, psychologists contribute from the initial moment of diagnosis through treatment, survivorship and palliative care, ensuring that psychological interventions are proportionate, timely and aligned with biomedical treatment goals (Rebecchi, 2018).

Accountability in clinical psychology can therefore be defined as the capacity of psychologists to justify their clinical and organisational decisions, demonstrate the outcomes and value of their interventions across care pathways and participate in the shared responsibility for the quality, equity and sustainability of public health services. This definition integrates clinical responsibility with institutional governance, positioning accountability as intrinsic to the public mandate of psychology rather than as an external administrative constraint.

As the organisational complexity of healthcare increases, accountability can no longer be reduced to individual professional responsibility. In integrated care contexts, such as mental health networks, oncology pathways or paediatric neurorehabilitation, psychologists contribute to collective outcomes that depend on coordination across disciplines and care settings (Burchard & Schaefer, 1992; Rosenberg & Salvador-Carulla, 2017). In these contexts, the effectiveness of psychological interventions is evaluated not only in terms of symptom change or individual progress, but also through their impact on adherence to treatment, continuity of care, reduction in inappropriate service utilisation and contribution to patient transitions. This system-level perspective reflects principles of value-based healthcare, in which outcomes are assessed in relation to the entire care process rather than isolated clinical episodes (Porter, 2010; Teisberg, Wallace & O'Hara, 2020). Similarly, within community mental health services, accountability is enacted through coordinated care across inpatient, outpatient and territorial settings, with interventions monitored through outcome systems such as the *Mental Health Information System* (MHIS, *Sistema Informativo per la Salute Mentale* – SISM), which systematically tracks access, treatment transitions and outcomes (Ministero della Salute, 2024).

The increasing digitalisation of healthcare introduces further dimensions of accountability (WHO, 2021). Psychologists are now required to contribute to outcome monitoring systems such as MHIS, the national data system managed by the Ministry of Health, and to ensure ethical governance in the use of electronic health records and decision-support algorithms (Donia, 2025). Through these mechanisms, accountability expands beyond clinical practice to include digital transparency, data integrity and the active contribution of psychologists to the governance and evaluation of health information infrastructures. Taken together, these factors demonstrate that accountability in clinical psychology is inseparable from organisational complexity. It is enacted through processes that ensure alignment with public health objectives, transparency in clinical documentation and measurable contributions to the coherence and sustainability of care pathways. As such, accountability must be understood not only as a clinical responsibility, but as a core component of the institutional role and disciplinary identity of clinical psychology within the NHS.

Training and Competency Development as Strategic Levers

The integration of appropriateness and accountability as defining dimensions of clinical psychology within the NHS requires a reorientation of the competencies expected of psychologists, as training represents the strategic mechanism through which these principles become operational in practice. In this view, training is not limited to enhancing individual therapeutic expertise, but functions as a system-level lever that enables psychologists to contribute to clinical governance, pathway design, and public accountability.

This reorientation implies a shift from an exclusively clinical perspective toward a system-based model of practice, in which psychologists are expected to analyse care processes, interpret outcomes, participate in governance mechanisms, and collaborate within multidisciplinary teams (Ganju, 2006). Emerging models in Italy and across Europe highlight how training must be aligned with public health needs, organisational structures, and value-based service delivery (Rebecchi, 2018; NHS Digital, 2023; Donia, 2025).

From Clinical Skills to System Competencies

Traditional training models have focused primarily on diagnostic assessment and psychotherapy. However, the current healthcare framework requires psychologists to acquire competencies that support accountability and appropriateness within public systems. These include understanding governance processes, contributing to resource allocation decisions, and demonstrating the value of psychological interventions through measurable outcomes.

Table 3 – Core Competency Domains Required for Appropriateness and Accountability

Competency Area	Description	Relevance to Appropriateness and Accountability
Evidence-based decision-making	Selection of interventions aligned with guidelines and clinical needs	Ensures clinical appropriateness and proportionality
Care process analysis	Mapping of care pathways and identification of critical transitions	Supports accountability and integration across services
Health system literacy	Understanding of NHS governance, ELC standards, and policy frameworks	Enables participation in planning and resource allocation
Outcome measurement	Use of routine and clinical indicators	Demonstrates accountability and public value
Interprofessional coordination	Capacity for shared decision-making and collaborative practice	Operationalises accountability in complex care contexts

Adapted from Ganju (2006), NHS Digital (2023), and Donia (2025), this table summarises the core domains of competency required for clinical psychologists to align their practice with principles of appropriateness and accountability in public healthcare systems.

Training Pathways and Institutional Convergence

The development of competencies relevant to appropriateness and accountability is not confined to a single phase of education but emerges across the continuum of training. At undergraduate and postgraduate levels, exposure to concepts such as clinical governance, digital health records, and health system organisation provides a

foundational understanding of the institutional context in which psychological interventions are delivered. This does not imply prescribing curricular change, but rather reflects an ongoing convergence between academic preparation and the evolving requirements of public healthcare systems. During postgraduate training, supervised placements within NHS services play a crucial role, enabling trainees to engage in multidisciplinary care processes, participate in the implementation of care pathways, and apply outcome measurement tools in real-world settings (Rebecchi, 2018). Continuing professional development further supports adaptation to emerging governance requirements, particularly in areas such as outcome documentation, stratification of care intensity, and participation in accountability frameworks.

Partnerships between universities and NHS organisations serve as strategic platforms for aligning training with public health priorities. These collaborations contribute to the gradual evolution of a professional identity that integrates therapeutic expertise with a broader governance orientation. While such developments are still in progress, emerging postgraduate models indicate a shift towards training pathways that prepare psychologists to contribute not only to clinical outcomes but also to service planning, quality assurance, and system sustainability.

The IAPT Programme as a Strategic Case of Training-Embedded Accountability

Within the European landscape, the United Kingdom's Improving Access to Psychological Therapies (IAPT) programme represents a key example of how training can be strategically aligned with public health governance. In the IAPT model, psychological interventions are delivered within a stepped-care structure, where each level of intervention is linked to performance indicators, standardised monitoring, and accountability mechanisms (NHS Digital, 2023). Training is explicitly structured to support this architecture, ensuring that psychologists develop competencies necessary to deliver proportionate care, document outcomes, and contribute to the overall value of the healthcare system. The IAPT model illustrates how accountability,

when embedded in training, becomes internalised as a component of professional identity rather than perceived as an external administrative burden.

Future Competencies: Digital and Algorithmic Accountability

Digital transformation is increasingly reshaping the governance of healthcare systems. Psychologists are now expected to engage with digital infrastructures for outcome reporting, participate in the management of electronic health records, and critically assess algorithmic tools used in decision support systems. Digital accountability encompasses transparency in data usage, ethical oversight of predictive analytics, and active participation in the regulation of emerging technologies (Donia, 2025). These competencies are fundamental to ensuring that psychological expertise informs the design and monitoring of digitally mediated pathways, safeguarding both professional autonomy and the quality of care.

Training as Necessary but Not Sufficient

In several NHS contexts, such as oncology care pathways, mental health networks, and community services, psychologists in training are progressively integrated into multidisciplinary teams where clinical decisions must be justified in terms of appropriateness and accountability. Through supervised participation in care planning, pathway coordination, and outcome monitoring, these training experiences operationalise the proposed framework by aligning individual clinical competence with system-level governance principles. This process is further supported by emerging collaborations between universities and NHS organisations, which integrate modules on care pathway management, patient-reported outcome measures, and data-informed decision-making into postgraduate training, thus providing a structured environment in which appropriateness and accountability become formative criteria rather than external constraints.

Strategic Phases for Integration within the National Health Service (NHS)

This section presents an original conceptual model outlining progressive phases through which appropriateness and accountability become embedded within the NHS. The progressive integration of clinical psychology into the governance architecture of the NHS can be conceptualised as unfolding through distinct but interconnected strategic phases. These phases are not prescriptive policy recommendations; rather, they serve as an interpretive framework that maps current developments and identifies trajectories for the institutional consolidation of clinical psychology. The framework reflects how appropriateness and accountability evolve from conceptual principles to operational mechanisms embedded within care structures, governance systems, and public policy.

Phase 1: Institutional Recognition. The first phase is marked by the formal acknowledgment of clinical psychology as a discipline that contributes not only to individual treatment but also to system-wide objectives of equity, quality, and sustainability. Institutional recognition has been reinforced by recent healthcare reforms, including the introduction of the primary care psychologist and the formal positioning of senior clinical psychologists within specialist settings (Ricciardi & Tarricone, 2021; Rebecchi, 2018). These developments clarify the presence of psychological services across multiple levels of care and highlight their relevance to clinical governance, thus establishing a foundation for appropriateness through role differentiation and access criteria.

Phase 2: Functional Integration. The second phase involves the embedding of psychological services within clinical pathways, governance mechanisms, and accountability systems. In this phase, psychologists participate actively in multidisciplinary steering groups, contribute to the design and monitoring of CCP, and engage in outcome measurement using tools such as patient-reported outcome measures.

Functional integration ensures that psychological care is aligned with institutional goals, proportional to clinical need, and evaluated through transparent documentation and public reporting mechanisms (Arah *et al.*, 2006; Scally & Donaldson, 1998). This phase operationalises

accountability by embedding psychological interventions within coordinated pathways rather than isolated clinical episodes.

Phase 3: Structural Consolidation. The third phase is characterised by the stable institutional positioning of clinical psychology within the NHS. Structural consolidation involves the formal establishment of organisational units dedicated to psychological services, recognition of clinical psychology within governance bodies, access to digital accountability infrastructures, and institutional mandates that define professional roles in service planning and evaluation. At this stage, clinical psychology is not merely present within the system; it becomes a structural component of health governance, participating in strategic decisions related to resource allocation, quality assurance, and public health outcomes (Wiktorowicz *et al.*, 2020; Nejatian *et al.*, 2024). The sequential development of clinical psychology within the NHS can therefore be represented through a strategic integration model. Table 4 summarises the three phases of this progression, specifying their core focus, institutional actors and expected system-level outcomes.

Table 4 – Summary of Strategic Integration

Strategic Phase	Core Focus	Primary Actors	Expected Outcome
Institutional Recognition	Formal acknowledgment of disciplinary role and scope	Ministry of Health, Regional Authorities	Inclusion in NHS planning frameworks and care models
Functional Integration	Participation in PDTA, outcome monitoring, appropriateness assessment	PDTA steering groups, NHS organisations	Coherent integration into care pathways and clinical governance
Structural Consolidation	Establishment of dedicated structures, digital accountability systems, institutional mandates	Health authorities, universities, governance bodies	Stable institutional positioning and enhanced accountability

Interpretive model illustrating the progressive institutional integration of clinical psychology within governance structures of the NHS

This model does not prescribe a linear policy agenda, but provides a conceptual roadmap that reflects current trajectories in the institutional evolution of psychology within the NHS.

Strategic Alignment with Policy and European Frameworks

The phased development of clinical psychology is supported by national policy initiatives, EU-funded reforms and value-based healthcare models that emphasise transparency, appropriateness and accountability as criteria for sustainable healthcare delivery (Ricciardi & Tarricone, 2021; WHO, 1986). Alignment with these frameworks enables psychological services to contribute to population health priorities and reinforces their institutional legitimacy within the NHS. Taken together, this strategic trajectory illustrates how appropriateness and accountability evolve from conceptual principles into operational pillars that redefine the institutional role of clinical psychology. Through progressive phases of recognition, integration and consolidation, the discipline transitions from a predominantly therapeutic function to an embedded governance role aligned with system-wide objectives of equity, sustainability and value-based care.

Conclusion and Future Directions

This paper has proposed a conceptual framework positioning appropriateness and accountability as foundational dimensions of clinical psychology within publicly funded health systems. By reframing these constructs not as administrative requirements but as core disciplinary principles, the model offers a theoretical contribution that fills a gap in the literature, where clinical psychology has traditionally been examined primarily in relation to therapeutic effectiveness rather than institutional governance and public value.

Rather than presenting empirical findings, this contribution offers a conceptual and policy-oriented framework designed to guide the institutional development of clinical psychology within the NHS. The framework establishes the conditions under which appropriateness and accountability can be translated into governance mechanisms, organisational structures and professional practices, thereby supporting the system-level evolution of psychological services.

The implementation of this framework is not without challenges. Structural barriers include the fragmentation of psychological services across regions, limited managerial autonomy, and the absence of

standardised outcome monitoring systems. At the same time, several enabling factors are emerging, such as the institutionalisation of clinical care pathways, the introduction of primary care psychology, the availability of digital health infrastructures, and growing policy attention to transparency and value-based care. These elements represent concrete opportunities through which appropriateness and accountability can be progressively embedded in the organisational architecture of the NHS.

Future developments should focus on piloting this conceptual framework within selected NHS contexts, in order to assess its feasibility and explore how appropriateness and accountability can be operationalised as system-wide criteria for evaluating psychological services.

By providing a coherent disciplinary model, this framework supports the evolution of clinical psychology from a primarily therapeutic profession to a governance actor capable of contributing to the equity, sustainability and public value of the NHS.

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Models of Value Construction:
A Culturalist Perspective

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Abstract

Research on organisational culture has mostly been based on two main types of interpretative models: a normative-typological paradigm that identified universalistic cultural types (Cameron & Quinn, 2006; Schein, 1985), and a symbolic-interpretative paradigm based on the analysis of discursive processes and sensemaking (Weick, 1995). However, both perspectives have limitations when it comes to capturing the dynamic, affective and situated nature of culture in organisational contexts. To address these limitations, this paper proposes a theoretical processual model inspired by Semiotic Cultural Psychology Theory (SCPT; Salvatore *et al.,* 2019a; 2019b) and the local culture perspective (Carli & Paniccia, 1999). This model conceives of organisations as symbolic fields that shape relationships between actors, institutional roles, and discursive devices. At the heart of this discussion lies the paradigm of Models of Value Construction (MVCs), understood as latent configurations of meaning based on affective polarities and social representations that guide action in organisational contexts. This paper also proposes empirical developments of the model to offer tools for analysing organisational culture as a situated, non-standardisable artefact that generates well-being or maladjustment depending on the congruence between the representations of organisational actors and institutional goals, offering a useful framework for intervention in complex organisational contexts.

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Beyond Taxonomy: Towards Dynamic and Situated Models of Organisational Culture

In the extensive landscape of studies on the functioning of organisations, the concept of culture plays a central role in understanding the processes that determine the identity of organisations themselves and their transformations. This construct of organisational culture encompasses many aspects, including the system of norms and values on which it is based, the discursive practices that regulate it, and the shared representations that emerge from relationships. In observing and understanding organisational change, considering all these aspects plays a strategic role. There are many ways in which organisational functioning and change have been studied; one of the most renowned contributions is the *Competing Values Framework* (Cameron & Quinn, 2006), originally proposed by Quinn and Rohrbaugh (1983), which maps organisational culture along two axes: internal/external and flexibility/control orientation. These axes represent value polarities, and the intersection of these axes determines the semantic plane on which the different cultural preferences of an organisation are located. Regarding the initial axis, when polarity is the internal focus, values are attributed to the well-being of members and the internal cohesion of an organisation based on integration. Conversely, the external focus indicates a tension towards the external environment and a proactive stance on the part of the organisation towards subjects or contexts that are considered relevant. The second axis pertains to the mode of regulation, and at one extreme, involves a flexibility-oriented approach that promotes adaptive and transformative logic; at the other extreme, there is an orientation towards stability with the implementation of standardised processes and predictable performance.

Four models of organisational culture emerge from the intersection of these two axes (Cameron & Quinn, 2006): the first model is called *Clan Oriented*, is characterized by internal focus and flexibility, and aims to promote an environment of cooperation and cohesion based on a sense of belonging and emotional involvement; in a similar

model, the organisation is seen as a family and leadership is oriented towards personal development through the exercise of empathy. The second model is defined as *Adhocracy Oriented*, it is an approach characterised by extreme openness to change, which translates into a propensity to innovate but also to take risks; it is therefore a model suitable for highly turbulent contexts, where flexibility and experimentation are indispensable resources. The third model is defined as *Marketing Oriented* and is also outward-looking, characterised by strong competitiveness and a focus on performance. In this case, the focus of the organisation is on achieving results, efficiency standards and market objectives. Leadership is execution-oriented and directive. Finally, we find the *Hierarchical Oriented* model, which is characterised by control and adherence to formal rules. Leadership in this case is administrative, exercised within codified structures and regulated by bureaucratic principles. This model is a typological interpretation of organisational culture.

Alongside this, we also find the approach proposed by Chatman *et al*. (2014), which identifies three fundamental aspects within culture: the *normative content*, which consists of specific values shared by its members; the *cultural consensus*, which refers to the degree of agreement that members reach around the norms; and the *normative intensity*, which indicates how strongly the norms are supported and reinforced within the organisation. This model therefore emphasises the normative dimension and defines an organisation according to the degree of consensus that is built around this dimension. The transformative potential of an organisation is determined by the content of its norms, and if these are oriented towards adaptation and learning, then creative behaviours can be generated that are more effective in contexts of high uncertainty. The consideration of uncertainty levels in contexts is pertinent, as evidenced by numerous studies that underscore the intrinsic interconnectedness between the human need for meaning and the pursuit of reducing uncertainty through narrative construction (De Luca Picione & Fortuna, 2025; Gamsakhurdia, 2020).

The models considered here (Cameron & Quinn, 2006; Chatman *et al*., 2014), which outline the types and normative structures of organisational cultures, have operated according to a top-down logic, classifying organisations into predefined types based on universalistic and normative assumptions. The approaches of Cameron & Quinn (2006)

and Chatman *et al*. (2014) are fairly classical approaches, which have had the merit of highlighting the implicit dimension of organisational meanings but have remained aligned with a view of culture as a set of relatively stable assumptions (Schein, 1985). Increasingly, critical works have highlighted the limitations of these models and emphasised the need to move beyond the conception of culture as static set of characteristics and to adopt perspectives capable of grasping the dynamic, generative and intersubjective nature of culture itself (Alvesson & Willmott, 2002; Ashkanasy *et al*., 2000; Jung *et al*., 2009). Such static approaches overlook how culture emerges from the continuous interaction between actors, discursive practices and contexts, and thus require the adoption of bottom-up interpretive models that are sensitive to local processes of meaning construction (Mantere, 2000; Weber & Dacin, 2011).

Attempts to overcome the limitations of taxonomic models include the *Management by Values* paradigm proposed by Dolan and Raich (2013) and the *Coaching by Values* paradigm (Dolan, 2011), according to which culture is understood as the dynamic configuration of three value axes: the first is characterised by *economic-pragmatic values* oriented towards efficiency and achieving productivity standards; the second concerns *ethical-social values* such as mutual respect and compliance with rules, responsibility and integrity; finally, the third concerns *emotional-spiritual values* (such as optimism or intrinsic motivation) that guide action. This tripartite model promotes a balance between pragmatic, ethical and emotional dimensions as the driving force behind an innovative organisational culture characterised by well-being. From this point of view, organisational well-being is not directly derived from performance but is defined as the result of a convergence between system of values and strategic perspective. For example, when organisational members experience what is known as "value congruence", this means that they perceive a strong match between the organisational culture and their own values; this leads to engagement, greater motivation and positive attitudes towards innovation (Bao *et al*., 2012; Dolan *et al*., 2011). According to this integrated approach, organisational culture begins to take shape as a mechanism that can generate well-being or maladjustment, depending on its ability to consider both the material and the symbolic and emotional needs of its members.

A clearer shift towards a processual and contextual paradigm of organisational culture can be seen in Weick's (1995) proposal that it should be understood not as a set of values or norms to be transmitted, but as something that emerges from sensemaking processes. Through these sensemaking processes, individuals shape the reality of the organisation by interpreting events, behaviours and decisions in contexts that often appear unstable or ambiguous. From Weick's (1995) perspective, which continues to be a paradigm worthy of attention for scientific research, culture does not precede action a priori but is constructed during action and changes in organisational interaction. In this view, we can see a theoretical shift in the definition of organisational culture from a rigid structure anchored in immutable values to an interpretive practice that takes place in the interaction between individuals and the organisation. Weick's view represents a break with normative and functional paradigms, his focus on the symbolic and discursive dimensions of meaning construction provides an epistemological bridge to other models that emphasise the affective dimension as a crucial element in organisational life.

The symbolic-affective paradigm of organisational culture finds its privileged expression in the model of "local culture" proposed by Carli and Paniccia (1999), an affective and collusive model of meaning construction in contexts. According to this perspective, further developed by Caputo (2013), the construct of local culture goes beyond traditional cognitive or normative conceptions of organisational culture. From Caputo's perspective, the local culture can therefore be understood as based on affective-symbolic processes. These processes refer to the manner in which members of the organisation, and institutional actors in general, construe the significance of their experience. Specifically, by local culture the authors mean a shared and emotionally connoted semantic field constructed through symbolic processes and affective collusion (Carli & Paniccia; 1999; 2002). Caputo's (2013) contribution deepens and extends this framework by highlighting, on the one hand, how local culture can be detected through the emotional analysis of texts. On the other hand, it can be defined as a field of semantic coexistence in which there is no standardisation of thoughts, but differences, tensions and collusive forms that shape the context and give shape to an emerging structure defined by relational trajectories and discursive practices (Carli & Paniccia, 2002). In this

framework, intervening in an organisational context means bringing out and then reorganising the underlying affective models that made the organisation cohesive or dysfunctional. Furthermore, in the Carli and Paniccia (1999, 2002) and Caputo's (2013) perspective, the notion of organisational well-being is far from that of job satisfaction or individual or group performance. In this context, well-being is an expression of a positive relational and affective function between the subject and the context and is expressed in terms of consistency between institutional roles and a shared symbolic representation of organisational goals. In other words, when local culture organises the field of emotions in accordance with institutional objectives, for example when members of the organization feel that there is alignment between the organisational culture, their own understanding of the context and their role, this leads to greater involvement and increased motivation and we can talk about organisational well-being (Carli & Paniccia, 2003).

This theoretical strand is linked to the perspective offered by Semiotic Cultural Psychology Theory (SCPT; Salvatore *et al*., 2019; Valsiner, 2007; Salvatore, 2016; Russo *et al*., 2020). SCPT has been shown to link the process of sensemaking – the symbolic-affective activity through which individuals interpret their relationship with the world – to the ways in which interaction between subject and context takes place (Salvatore & Zittoun, 2011). According to SCPT, sensemaking is organised by "semiotic forcelines" (Salvatore *et al*., 2019), namely hyper-generalised, embodied, and affect-laden dimensions of meaning (Salvatore *et al*., 2022, 2024; Salvatore & Zittoun, 2011), which represent the fundamental structure by which individuals attribute meaning to reality. Semiotic force lines are defined as primary and elementary dimensions (Zajonc, 1980). The hypothesis is posited that these phenomena are not reducible to simpler units and are not mediated by cognitive processing. This finding suggests that they facilitate an immediate perception of the environment, operating outside of inferential reasoning (Salvatore *et al*., 2019). The semiotic forcelines are theorised to organise into patterns of implicit assumptions that foster and constrain how individuals make sense of and act within their organisational context. In other terms, the ways of interpreting context are not arbitrary but are structured around "latent dimensions". These dimensions are based on implicit emotional orientations and relatively

stable affective assumptions (Kerušauskaitė *et al*., 2023; Salvatore *et al*., 2019). In this theoretical scenario, organisational culture is not viewed as a static set of norms and values, but rather as an ongoing process of constructing meaning, conveyed through shared symbolic configurations that mediate interaction between individuals and their environment. Organisational culture provides the symbolic grammar through which individuals interpret events, roles, relationships, and purposes. This contributes to the definition of the conditions that make one's own actions possible (Valsiner, 2007; Salvatore & Venuleo, 2013).

Interest in value construction models (VCMs) has developed from this perspective, as a concept introduced to delineate relatively stable and affectively charged configurations through which organisations interpret their context and orient their actions. These "ways of being" in context do not derive from conscious choices or learned norms, but from structures of meaning that organise experience tacitly and in an embodied manner (Ciavolino *et al*., 2017). MVCs are semiotic patterns that structure the symbolic field in which the organizational actor subject acts and generate distinct ways of conceiving effectiveness, professional identity, customer relationships, mutual expectations, and the organisation's goals (Salvatore, 2018; Salvatore *et al*., 2019). Studying these patterns enables us to understand how latent patterns of behaviour are established in each organisational context, defining the organisation's culture.

According to the situated and processual cultural perspective proposed in this paper, it is worth noting that other recent models have highlighted the dynamic and co-constructed nature of organisational culture, as in the case of the Agile model of organisations in the context of digital transformation (Babayan & Babayan, 2025) or the "Intelligent Enterprise" paradigm (Kondreddy & Rastogi, 2025), which offers a conceptual framework consistent with the symbolic-affective view of the organisation as a situated semantic field. Also relevant to the present aims is the model proposed by Li (2025), which emphasises the continuous co-construction of meanings between organisational mission and stakeholders, in a perspective aligned with the dynamic visions proposed.

Models of Value Construction (MVCs) and Organisational Paradigms

This theoretical evolution, from normative and typological models to conceptual frameworks based on processes and symbolic-affective models, invites a broader epistemological reflection on the worldviews underlying organisational paradigms. In this conceptual context, the following investigation will explore how organisations embody these general visions, which can be defined as Models of Value Construction (MVCs) and define their mission through culturally rooted frameworks. These general paradigms, as fundamental epistemological frameworks, determine the form and function of the organisation itself, as well as how it conceives its value and mission (Hatch, 2018; Harrison & Carroll, 2021).

It is possible to distinguish between two predominant paradigms that emerge as an outcome of the relationship between the subject and the environment and that characterise organisational cultures by orienting their action (Salvatore *et al.*, 2019c). The first is called the Agent-Centred Model (ACM), and the second is called the Context-Centred Model (CCM). In the ACM paradigm, the focus is placed on the operational and normative conditions of the action, while the context – which issues inputs and receives outputs – does not constitute a regulating principle of the action. It is a technocratic and performative paradigm focused on procedural, efficiency and control aspects. Consequently, the sense of value is defined by performance and adherence to internal standards (Carli & Paniccia, 1999). In an organisation that employs an action-centred paradigm, work dynamics are structured around tasks, hierarchies and objectives of the production process (quality standards, cost reduction, etc.) and demands from the context – such as customer or employee needs – are addressed by organisational mechanisms. These mechanisms serve the exclusive purpose of maintaining organisational efficiency (Thompson, 1967). However, there is a risk of implementing unsuccessful strategies, particularly in cases where environmental variability and instability render pre-established standards unattainable.

The Context-Centred Model (CCM) presents a different perspective by inverting the conventional logic of the aforementioned models. In this paradigm, the environment and its variability are recognised as

the primary determinants of action. In accordance with this theoretical framework, the organisation acknowledges a preeminent normative function attributed to the environment, to which it adapts in response to its demands. In such cases, the actions of the parties involved are subject to regulation by devices that emphasise the consumer's perspective, with the regulatory framework being shaped by the demands that are accommodated and interpreted (Norman, 1986; Salvatore *et al.,* 2019a). This second paradigm emerges from the questioning of the ACM, which has been demonstrated to be a suboptimal adaptive model in contexts characterised by high complexity demand, as evidenced in educational settings or in hypercompetitive markets characterised by low environmental stability (D'Aveni & Ravenscraft, 1994).

In order to transform themselves into systems that are receptive to environmental demands, organisations adapt to these through practices of service customisation and the inclusion of the user (*prosumer*) in a process of co-creation of the service (Ciavolino *et al.*, 2020; Ciavolino *et al*., 2019), and of the value associated with it (Salvatore, 2016). Consequently, within an organisational framework founded on such a flexible paradigm, value is generated through relationships with others and the collaborative construction of meanings (Salvatore *et al*., 2019; Russo *et al*., 2020).

Nevertheless, it is imperative to acknowledge the constraints imposed by the CCM. One limitation is that its continuous adaptation to the environment carries the risk of compromising the organisation's ability to self-organise according to its original vision and purpose.

ACM and CCM, in their respective merits and limitations, represent alternative paradigms, which are overcome in a Dynamic Model (DM) founded on a dialectical and transformative relationship between subject and context, between action and environment (Salvatore *et al.,* 2019a; Salvatore, 2018). The model under discussion is rooted in cultural and dialogic psychology (Salvatore, 2016; Valsiner, 1999) and interprets organisational action as the continuous co-construction of meaning and value within interaction. According to the DM, the organisation does not engage in direct action by means of the imposition of an internal regulatory framework (as in the ACM model), nor does it undergo change and adaptation in response to environmental pressures (as in the CCM model). Rather, the organisation should be

understood as a space of continuous negotiation between intentionality and environmental constraints, characterised by boundaries that are redefined at both the operational and symbolic levels.

In previous models, the environment was understood as a constraint or resource. Conversely, in this model, it is described as a relational and semiotic field in which action takes shape and direction. In this context, organisational practices act as generative devices of meaning (Bendassoli *et al*., 2019; Salvatore *et al*., 2019) and organisational action takes the form of a process of continuous re-actualisation of the organisation's identity in relation to the multiplicity of environmental demands. In circumstances where tensions emerge from interaction with a highly unstable and complex environment, the DM interprets this tension as a semiotic resource with the potential to instigate change in the organisational culture. To elaborate, it promotes a process-based vision in which the processes of re-signification of one's relationships with the environment are deemed to be the prerequisite for organisational well-being. For instance, the emergence of conflicting demands from customers, torn between efficiency and personalisation, has the potential to trigger a redefinition of the organisation's value system. Rather than the adoption of measures designed to suppress tension, the organisation could implement reflective practices that would lead to a redefinition of its mission. In this case, the mission could be changed from "providing quick solutions" to "co-creating meaningful experiences". This change illustrates how DM leverages uncertainty as a catalyst for cultural transformation, treating interpretative conflict as a resource for meaning creation and organisational well-being (Bendassoli *et al*., 2019; Salvatore *et al*., 2019).

Empirical Applications and Methodological Developments

From a methodological perspective, the SCPT has given rise to the development of innovative tools for the analysis of meaning construction processes. A relevant example of this is the Models of Value Construction Questionnaire (MVC-Q), which has enabled the mapping of implicit semiotic configurations that guide the construction of value in organisations (Salvatore *et al*., 2019). The items contained within the first part of the questionnaire were designed to elicit perceptions,

judgements and opinions regarding the meanings underlying behaviour within the organisational context. The purpose of these items is to stimulate perceptions of the organisational context, the representation of the environment, and the representation of the role within the organisation. The items in the second part of the questionnaire function as illustrative variables (Lebart, Morineau & Warwick, 1984) and are employed to describe segments of the population defined by a specific meaning model (MS; Venuleo, Mossi & Salvatore, 2014).

Recent applications are founded upon quantitative designs of an exploratory nature, with the objective of identifying those latent dimensions of meaning that represent stable ways of constructing value within an organisation (Gennaro *et al*., *submitted;* Salvatore *et al*., 2019). The authors pursue the objective by implementing two analysis techniques. Firstly, Multiple Correspondence Analysis (MCA; Benzecrì, 1992; Benzecrì & Bellier, 1973) is used to explore the latent meaning structure of the data collected through the MVC-Q. It is indeed possible to reduce dimensionality by means of MCA, through the identification of factorial structures that synthesise the variability of the data and describe a semantic space in terms of primary meaning structures that shape organisational dynamics. In the context of MVCs, this type of analysis facilitates the mapping of the patterns of meaning by which subjects interpret (attribute value) to organisational practices. It is imperative to emphasise that the dimensions of meaning that emerge should not be interpreted as static psychological factors. Rather, they should be regarded as affectively charged lines of force that organise to experience (Salvatore *et al*., 2019).

In a secondary step, the authors have implemented a Cluster Analysis (CA; Gore *et al*., 2006) to identify homogeneous response profiles assimilated to different Value Construction Models. It can be argued that each cluster represents a shared, sufficiently stable cultural profile indicative of how a certain number of individuals interpret experience in each organisational context (Gennaro *et al*., *submitted*). As part of the empirical study conducted by Salvatore and colleagues (2019), in order to identify latent configurations within organizational contexts, a questionnaire was developed based on the assumptions of the ISO (organisational development indicators) methodology proposed by Carli and Paniccia (1999). This approach does not entail the utilisation of questions that are characterised by clear and defined meanings (e.g.,

satisfaction ratings, opinion/reputation surveys or assessments of past experiences; etc.) (Caputo, 2013). Rather, it involves the examination of a complex set of emotional dimensions and psychosocial patterns that can identify the specific cultural and symbolic components of the respondent.

The tool was subsequently administered to Italian operators and managers, selected according to convenience criteria, of eight disparate organisations in the fields of education, social welfare, financial brokerage, real estate brokerage, commerce and e-commerce, tourism and transport sectors. A total of 139 questionnaires were completed (with equal proportions of men and women, 50% of participants being aged between 40 and 59 years old, and an average age of 42.85, with a standard deviation of 10.84). Regarding geographical distribution, the overwhelming majority of questionnaires – precisely 136 out of the total 139 cases – were completed in southern Italy. Distribution was determined by strategic or operational role within the sample, with 68 and 71 individuals, respectively (Salvatore *et al.*, 2019).

Authors identified five MVCs, in the form of clusters, which refer to five MS (Venuleo, Mossi & Salvatore, 2014) that guide experience in the organisation and act as real devices regulating organizational culture. One cluster, designated as *Strategic partnership*, pertains to an organisation that is regarded as a resource for the customer. In this context, the customer is not merely a recipient of needs or a mere consumer, but rather a genuine partner, a contributor of skills, and an active participant in the design phase. The model under discussion is predicated on co-design and mutual investment, with the relationship itself being conceptualised as a space in which shared values are generated. This cluster suggests a model for understanding the phenomenon of mutual recognition and collaboration as a central element. This concept is reflected in a symbolic representation of the organisation as a network of alliances, with value being attributed to collaborative responsibility and horizontal trust. Another cluster, defined as *Symbolic power*, concerns the organization's ability to intercept and shape customer expectations; organisations guided by this vision act as symbolic mediators between customer representations (perceived as desiring, non-expert subjects) and institutional goals; the customer is presented with a proposal that "captures" them and contributes to defining their identity. Another cluster focuses on *Aknowledgment of technical*

quality; customers are regarded as competent, and value is derived from external perceptions of the technical quality. In this output-oriented vision, the organisation does not incorporate the customer into the production process; rather, the customer is regarded as an external evaluator of the organisation's technical effectiveness. Fourth cluster has been defined as *Dependency on the autonomous client*, and involves recognizing a customer as autonomous, with their own projects and capable of evaluating the organization's actions. Consequently, the latter is dependent on the customer's vision, which it uses to justify its own intervention, based on the trust that the customer, regarded as an external regulator, bestows upon it. Finally, the authors identified an additional cluster defined as *Intrinsic quality of performance*; in this cluster, there is a sense of value that is intrinsically connected to internal technical competence and the quality of organizational action, regardless of the judgment of the customer, who is understood as the object of the intervention. This is an executive and self-referential model in which value is contingent on adherence to technical and operational standards.

The five MVCs described outline a highly intricate symbolic domain, distinguished by diverse interpretations of the relationship between representations of the organization and customer, and operational methodologies. The approach delineated herein eschews the classification of MVCs in purely descriptive terms, but rather as symbolic configurations that can be placed on a semantic field with two latent dimensions. These dimensions represent two axes of symbolic-affective differentiation that delineate the cultural meanings attributed to organisational action. The first axis concerns the locus of value regulation, which can be regulated internally, i.e. generated by technical, procedural or symbolic processes within the organisation, or externally, i.e. attributed on the basis of recognition by external actors, in particular users or the social context of reference. The second axis pertains to the representation of the customer/user. This can be conceptualised as a entity passively receiving organisational action, the recipient of services and rules defined autonomously by the institution. Conversely, it can be conceptualised as an active partner in the co-construction of value involved in a dialogical and cooperative manner in the definition of objectives and actions. Whilst the *Strategic partnership* and *Symbolic power* models attribute a significant role to the

customer in the co-construction of value, models such as *Acknowledgment of technical quality* and *Intrinsic quality of performance* are characterised by a procedural and self-referential perspective of action. The *Dependency on the autonomous client* model, while acknowledging the value attributed to the customer who is external to the organisation, does not exercise any action on it. The analytical approach delineated in this study is proposed as a means of interpreting organizational culture as a dynamic field of symbolic devices. In the emergence of a model based on strategic partnership, it offers a glimpse of a desirable evolutionary trajectory towards dialogic and co-constructive forms of cultural richness, in line with the theoretical framework of DM.

In accordance with the assumptions of SCPT, it is important to interpret the results presented herein within the framework of a situated and context-dependent perspective, and it is essential to refrain from interpreting them in a nomothetic sense. Indeed, an empirical approach centred on MVCs aims to capture symbolic configurations latent within local organisational cultures, rather than producing universally applicable categories. The value of the theoretical framework presented here lies in its interpretative potential rather than in statistical generalisation. This limitation presents several promising prospects for future empirical developments, including comparative studies across sectors and on organisational change processes. For instance, Gennaro *et al*. (*submitted*) are employing the present approach to explore symbolic dynamics in novel organisational contexts.

Conclusions

The theoretical path delineated above underscores the mounting significance of culturalist approaches in the domain of organisational studies, particularly in highly intricate domains. In this study, the transition from taxonomic and normative models to symbolic-affective models is traced, and it is demonstrated that a paradigm based on MVCs serves as a true *hermeneutic device* (Salvatore & Freda, 2011) for interpreting the processes of meaning through which organisations delineate their actions. The MVC perspective is predicated on models that do not presuppose values as pre-existing and normative; rather, it emphasises the affectively connoted essence of organisational culture,

which regulates forms of belonging and identity construction. From an epistemological perspective, the conceptualisation of three paradigms – the Agent-Centred Model (ACM), the Context-Centred Model (CCM), and the Dynamic Model (DM) – has sought to underscore the fallacy of perceiving organisations as monolithic entities governed by immutable rules. Notably, the DM has advanced a dialectical interpretation of the nexus between internal motivation and contextual limitations, accentuating organisations' capacity to transform tensions into symbolic resources that can be instrumental in catalysing change.

From a methodological perspective, the MCV Questionnaire (MCV-Q) was presented as a tool to elucidate the affective-cultural grammar of an organization. Indeed, it was designed to empirically map value construction patterns, with the objective of guiding interventions aimed at organizational development and well-being. While the primary aim of this study was to delineate the theoretical and epistemological underpinnings of the MVC paradigm, it is imperative to underscore the potential applications and interdisciplinary utility of this model from an empirical standpoint. This approach would be beneficial for mapping practices in various professional fields where there is a necessity to comprehend behaviour not solely as a response to exogenous variables, but chiefly as the consequence of symbolic-affective processes.

In the domain of clinical-organisational studies, for instance, an MVC-based approach facilitates the exploration of the symbolic representations that are characteristic of care contexts. This is particularly evident in the establishment of the doctor-patient relationship and the regulation of the climate within healthcare organisations (Caputo, 2013). In general, within a clinical context, MVCs can be utilised to map the implicit representations of care, patients, and roles that affect team functioning and user experience.

In the domain of education, the MVC paradigm is expected to primarily enable an examination of how various stakeholders within the school environment (e.g., teachers, support teachers, students, and families) and institutional bodies interpret concepts such as school success, inclusion processes, or learning difficulties. Secondly, it is anticipated that this paradigm will facilitate a deeper understanding of how these interpretations influence the structuring of educational relationships (Salvatore *et al.*, 2019; De Luca Picione & Valsiner, 2017). For instance, within these contexts, it is possible to observe how

parents and teachers interpret learning disorders within the context of deeply culturalized symbolic horizons. These interpretations can influence the organisation of the educational relationship; in these situations, an MVC approach facilitates the discernment of symbolic tensions between institutional and contextual mandates and pedagogical identity, allowing professionals in the field to understand the demands coming from families and institutions and to integrate them into an educational intervention consistent with development goals.

The field of marketing represents a further context in which an MVC-based approach can furnish suitable criteria for comprehending the symbolic-affective models on which the dynamics of service production and communication practice design are predicated, and the way consumers are conceptualised and engaged (Ciavolino *et al.*, 2020; Ciavolino *et al.*, 2019). Furthermore, in this context, MVC-based approaches can be useful for both understanding and enhancing the symbolic dimension of the offering. These approaches can assist stakeholders in recognising that products and services are desirable not only for their cost or function, but also for the identity positioning they offer and promote (Zott *et al.*, 2011).

When considering these and other contexts of application, the MVC-centred approach can be defined as a cross-cutting conceptual and operational device capable of capturing the structures of meaning that guide action. Furthermore, it can be defined as a tool for promoting practices that align institutional mandates with subjective and environmental demands.

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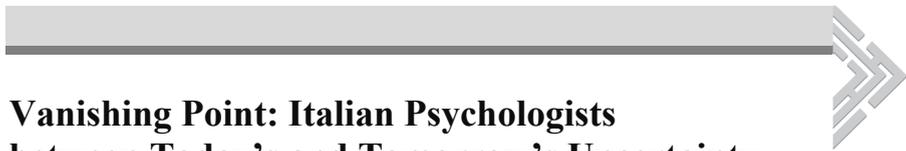
Vanishing Point: Italian Psychologists between Today's and Tomorrow's Uncertainty

Pietro Stampa[*]

Abstract

The profession of psychology in Italy is undergoing a period of rapid expansion that simultaneously threatens its very nature as we have known it until quite recently. The main critical issues are: (1) the limited level of professional practice-oriented education provided by university programs; (2) the trivialization of the profession's public image due to a consumerist use of social media; (3) the proliferation of pseudo-psychological support services offered by unqualified practitioners, such as counselors and coaches; (4) the challenge posed by online psychological counseling, which has opened the market to platforms with largely uncontrollable effects on new and unprecedented modes of service delivery; (5) the challenge of artificial intelligence (AI) applied to psychological services. These critical issues are examined from a historical, legal, and deontological perspective.

Keywords: Academic education, professional practice, public image, Artificial Intelligence.

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Present shadows, foreshadowing deeper shadows to come.
Herman Melville[2]

Ouverture

Professional psychology in Italy has never been as popular as it is today. Paradoxically – and precisely for the same reasons underlying this popularity – it has also never been so close to the risk of self-extinction. We are facing the undesirable prospect of a slow and gradual implosion which, sooner than we might hope, could lead to the collapse and dissolution of the profession itself into the diffuse, undifferentiated landscape of various helping practices and promotional activities promising a vague and longed-for "well-being", based on linguistic exchange and/or bodily training. ("Well-being": a term perhaps never so ambiguously overused – both within and beyond psychology).

At least within the geographical and legal boundaries of Italy, five main critical issues currently pervade the profession in this phase of its now fifty-year-long development.

These five issues, which I will list in logical (though not necessarily hierarchical) order – since it is difficult to determine priority among them, given that we do not yet know how the situation will evolve, and what today appears secondary may tomorrow prove central – are deeply interconnected and interdependent. For each, I will outline several "minor" corollaries or derivative problems, again without assigning them any rigid hierarchy (as Sherlock Holmes would say, "It is of

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[1] *Even in the narration of a story, as in the case of clocks (which, after all, narrate time), some wheels must turn backwa*rd – "Ruotismi", in *Horror vacui*. Rome: OET, 1945: p. 158. Leonardo Sinisgalli (1908-1981) has been an excellent Italian poet, essayist and mathematician.

[2] "Benito Cereno", in *Piazza Tales*. New York: Dix & Edwards, 1856: third paragraph.

the highest importance, therefore, not to have useless facts elbowing out the useful ones")[3].

The critical issues are as follows:

(1) The University System's Persistent Difficulty in Providing Professional Practice-Oriented Education. The Italian university system has long failed to equip future psychologists with genuinely professional, pragmatic, and operational training grounded in applied rather than purely theoretical concerns. The education of psychologists remains largely focused on the self-referential needs of academia rather than on a genuine need assessment of the profession in light of current and emerging market demands – demands that are transforming rapidly for all professions, not least under pressure from the European Union.

(2) The Spread of a Simplified Public Image of Psychology on Social Media. On social platforms, the public image of the psychological profession has increasingly conformed to trivialized semiotic models – foremost among them, the overused and somewhat ridiculous "influencer" paradigm. The linguistic and visual codes typical of social media are shaping professional self-expression in ways that flatten psychology into the language of common sense, forcing it to appear more as an agent of conformity than as a driver of social change.

(3) The Proliferation of Pseudo-Psychological Services Offered by Unqualified Pseudo-Professionals. Alongside these trends, we have witnessed an unchecked expansion of consulting and coaching services that blatantly and surreptitiously imitate psychological interventions without the requisite credentials. These are, more often than not, persuasive performers rather than legitimate helpers: "mental", "life", "love", or "teen" coaches (self-proclaimed "mentors of future generations"), as well as motivational speakers, trainers, and "relational", "existential", "neuro-cognitive", "socio-educational", or "strategic" counselors – new variants emerging constantly. This legion of pseudo-professionals practices psychology unlawfully (and largely with

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[3] Arthur Conan Doyle, "The Man with the Twisted Lip", in *The Adventures of Sherlock Holmes*, London: George Newnes, 1892.

impunity), in violation of Article 348 of the Italian Penal Code. Their online image, moreover, is often indistinguishable – in content and expression – from that presented by many licensed psychologists themselves (as noted in point 2), frequently lacking cultural depth and theoretical grounding, and relying instead on "techniques without theory".

(4) The Challenge of Online Psychological Assistence and Platform Mediation. The rise of online psychological services – where digital platforms act as commissioners or brokers of interventions – poses new challenges to the clinical and psychotherapeutic relationship. Such platforms reframe those who seek help from patients into consumers, exert downward pressure on the market both economically and culturally, and induce professionals to compromise on both technical and ethical standards. The introduction of this commercial "third party" into the field has caught the professional community off guard; its intrusion circumvents the legal framework governing Italian professions[4]. Only now is its actual cultural, economic, and legal impact beginning to be recognized – yet public and institutional debate lags behind, while this new reality expands virtually unchecked.

(5) The Emergence of Generative Artificial Intelligence as a Formidable Competitor. Generative AI has recently emerged as a powerful and unstoppable competitor in the domain of psychological assistance, often adopting modalities akin to those described in point (3). The debate on this topic – prompted by international, especially American, developments – has advanced rapidly in Italy as well, sometimes taking on apocalyptic overtones rather than maintaining critical distance, or, conversely, displaying excessive enthusiasm for the automation and acceleration of certain formal tasks.
Let us now examine these issues more closely.

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[4] Articles 2229 and following of the Civil Code.

Critical Issues (1) – The Problem of University Education

Immediately following the enactment of Law No. 56/1989 (Regulation of the Psychology Profession), a study group that named itself *Circolo del Cedro* – after the street in Trastevere, Rome, where its meetings were held (Circolo del Cedro, 1991, 1992) – highlighted how academic education in psychology appeared largely detached from the living reality of the profession. As noted in the group's reflections, this structural deficiency could be traced back to the original design of the Psychology Degree Program established in 1971 within the Faculty of Education at *Sapienza* University of Rome. That institutional context, shaped by a prevailing Catholic pedagogical culture, was distant from the labor market and oriented either toward theoretical research or toward educational practices focused on childhood and adolescence.

The curriculum was never adequately updated, neither with the growing diffusion during the 1970s of private psychotherapeutic practice – and the related training promoted by emerging institutes targeting the first psychology graduates – nor with the establishment of the Italian National Health Service in 1978, which began to integrate psychologists into the public healthcare system[5].

The first of these two developments ultimately created a paradoxical cultural obstacle to the development of university-level education in basic clinical and psychological intervention. In part, the issue had a distinctly economic dimension: many psychotherapy school directors – often also university professors – appeared more interested in instilling within students the conceptual premises for subsequent specialization in their own psychotherapeutic model than in enabling them to provide general psychological support upon graduation. Such support could have been grounded in principles and practices derived from general, social, and developmental psychology and from a connected conception of the clinical domain. This was precisely the approach advocated by Daniel Lagache (1969) and reinforced institutionally by Law No. 56/1989, which in Article 3 subordinated the practice of psychotherapy to specialized postgraduate training while simultaneously introducing a system of ministerial recognition for private institutes.

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[5] For an accurate historical reconstruction of this process, see Lombardo, 1990, 1994, 2025; Calvi & Lombardo, 1989; Lombardo & Romano, 2022.

Article 1 of Law No. 56/1989 did foresee that certain explicitly clinical "first-level" activities – prevention, diagnosis, habilitation–rehabilitation, and support – could be carried out by non-specialist psychologists. Nonetheless, at that time, Italian psychology seemed to begin and end with psychotherapy alone (Carli, 1995).

Carli's critique was severe but accurate: he reproached university faculty for lacking the field experience necessary to construct professionalizing didactic models. However, he overlooked at least one significant innovation compared with earlier conceptions – namely, the establishment of the unified role of "psychologist", which thereafter became the definitive standard framework for both training and professional practice in private and institutional contexts.

In any case, the university reforms of recent decades have done little to improve training – if anything, the opposite. Law No. 240/2010 (so called *Gelmini* Reform)[6] introduced extensive changes to the university system, reorganizing governance and creating a new national Agency (ANVUR)[7] tasked with assessing the quality of research and teaching. State funding was henceforth to be regulated by performance-based "merit", and degree programs were to be consolidated for organizational and financial rationalization.

Fifteen years later, Italian universities continue to struggle with serious difficulties, many of which stem – at least in part – from that reform. The three most evident problems are: chronically insufficient funding; persistent disparities between the northern and southern regions in terms of resources and opportunities; and the slow, inadequate adaptation of education to the rapidly changing labor market.

ANVUR itself, designed to evaluate quality in higher education and research, has also been subject to significant criticism. Its procedures are often perceived as bureaucratic and excessively complex, requiring massive documentation and consuming substantial faculty time. Many of its criteria rely almost exclusively on quantitative indicators – such as publication and citation counts or graduate employment rates in formal jobs – even though in Italy temporary contracts remain the

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[6] Maria Stella Gelmini was the Italian Minister for Universities, Education, and Research in the Berlusconi Administration (2008-2011).

[7] Acronym for the National Agency for the Evaluation of Universities and Research.

norm. A predominantly quantitative approach risks missing the actual quality of teaching and research, as well as the real preparedness of students, privileging easily measurable aspects that are not necessarily representative of true educational effectiveness. Moreover, ANVUR tends to apply uniform evaluation criteria to all universities, disregarding local, and disciplinary specificities.

Among the various fields, psychology education seems particularly affected by a chronic disconnection between academic training and the living reality of professional practice – a gap that ANVUR has neither investigated adequately nor addressed through any meaningful developmental perspective.

Nearly fifteen years after the *Gelmini* Reform, psychology students still study – if at all – only marginally, briefly, and in a few universities (typically at the initiative of professional boards) the fundamental principles of ethics and law governing professional practice. This omission is striking, since in all other degree programs – even those with limited legal content – students preparing for professions involving personal responsibility toward clients and society are expected to master the relevant normative frameworks.

This "historical" gap in psychologists' basic education is especially troubling given that their professional activities – both in private practice and in public institutions – require a sound understanding of legal norms to make informed and responsible decisions with significant civil and criminal implications. These include not only accountability toward clients or patients, but also the complexity of interventions involving minors, incapacitated persons, or otherwise vulnerable or potentially dangerous individuals, for whom specific legal safeguards are required (Stampa, 2019).

Over the past decade, within the Ethical Committee of the Lazio Regional Board of Psychologists and in courses taught by external professionals at several universities, we have developed a structural model of professional ethics that conceptualizes it as an interface between the domains of ethics, law, and the theory and technique of psychological intervention – centered on the framework of *Demand Analysis* (Carli, 1987, 1993; Carli & Paniccia, 2003). In this model, the legal dimension represents the "hard kernel", defining the essential objective knowledge without which the professional lacks key tools for competent practice. Ignorance of legal and ethical prescriptions –

for instance, concerning professional secrecy, the duty to report, or the rights of non-custodial parents regarding their children's health and education – amounts to a level of unpreparedness incompatible with the exercise of the profession.

To illustrate: imagine a young architect entering the job market unaware of safety regulations at construction sites, environmental impact assessment procedures, or zoning and building permit requirements. Such a professional would not last a day. Schools of Architecture devote ample time to ensuring that students internalize the essential regulatory frameworks and operational concepts of their profession. The same is true of Medicine and Law, where future professionals are trained through continual emphasis on practical application, supervised simulations, and repeated exposure to real professional scenarios. In those faculties, it is no coincidence that professors are almost always active practitioners.

Not so in psychology, as I pointed out years ago in *Rivista di Psicologia Clinica* (Stampa, 2011) – a reflection that, today, appears even more alarming and instructive.

Indeed, within the Ethical Committees of our professional boards, we are often confronted with cases that astonish by the mixture of recklessness and ignorance displayed by colleagues accused of disciplinary violations. The most frequent involve conflicts among consultants in family law contexts, misuse of social media (see next Section), breaches of confidentiality due to misunderstanding of the "legitimate reason" (it. "giusta causa") exemption under Article 622 of the Italian Penal Code, and various forms of malpractice arising from failure or unwillingness to maintain professional boundaries. Yet, the overwhelming majority of ethical infractions among psychologists are unintentional – stemming from misinformation, incompetence, carelessness, or disregard for binding norms whose significance is underestimated. University education should, above all, provide the foundation for a level of competence that would render such gross distortions of psychological and ethical practice not merely unacceptable, but unthinkable.

Critical Issues (2) – The Public Image of the Profession

The considerations outlined above lead directly to the question of how psychologists have begun to use social media. Let us start with language. The non-technical use of psychological terminology is increasingly becoming the standard among psychologists themselves, blending – without oversight – into the suggestive and promotional lexicon typical of social media platforms[8].

A colleague specialized in sexology was summoned before a disciplinary board for her advertising on TikTok. One particularly illustrative case concerned a training package entitled "*Five Tricks to Stimulate the Penis*". There is no prudishness regarding the topic; rather, she was asked why she had chosen the term "*tricks*" instead of "*methods*" or "*techniques*", which are more neutral and more directly aligned with a scientifically rigorous approach. The colleague remained silent for a long time – much to her lawyer's embarrassment – and finally replied: "Well, "tricks" is an expression typical of social media language…". Exactly: of social media, not of psychology.

Indeed, technical terminology itself – having exited, as it were, through the front door of psychology to disperse into everyday language – has re-entered the profession through the back window, carrying with it the distorted meanings that common usage and media discourse have assigned to it over time. Expressions such as "*narcissism*", "*empathy*", "*trauma*", "*panic*", "*borderline*", "*comfort zone*", "*self-esteem*", "*guilt*", "*unconscious*" (now conflated with anything of which one is unaware), and "*stress*" (now conflated with anything tiring, annoying, or displeasing)[9] – are used routinely by psychologists on social media not with their codified scientific meaning, but with the meaning presumed to be easily understood by even the least informed follower. Each of these terms thus ceases to function as a conceptual tool for understanding and defining mental states and becomes instead an allusion, a knowing wink, a "nudge-nudge" exchange in which both parties pretend to have understood one another. Clients – as is entirely normal – frequently invite us into this kind of collusive complicity: an evocative word, referencing supposedly "obvious" features of the

[8] See Commissione Deontologica dell'Ordine degli Psicologi del Lazio (2024)
[9] A significant contribution to this topic is Argentieri & Gosio (2015).

mind and thus of behavior, is used to elicit the sharing of an implied, unspoken meaning assumed to be mutually understood.

Consistent with this approach – marketed as "popularization", "psychoeducation", or in any case *customer oriented* – social media overflow with stereotyped offerings that are progressively transforming what were once called "patients", "clients", or "service users" into consumers of quick advice, self-help exercises, and "cash and carry" solutions to a wide range of emotional and relational issues (the most common being "How to Win Back Your Partner in *n* Steps", complete with "The *n* Things You Must Not Do to Win Back Your Partner"). Psychological and clinical consultation, once "tailor-made", has become "prêt-à-porter".

A paradigmatic example from Instagram reads:

How to Be Happier with Positive Psychology. Learn the essential elements of positive psychology: take control of your happiness, change your moods at will, and master the flow state to achieve unprecedented results. All of this through exercises explained clearly and quickly. What you will learn: # How to change your emotional states more often and more rapidly, using your emotions as allies # How a simple exercise of a few minutes can put you almost instantly into a state of well-being # The little-known factors that undermine your happiness and serenity, and how to avoid them # How to master the flow state, a "powerful tool" that will allow you to achieve results never before attained # Much, much more…

Even granting a critical view of positive psychology – at least as originally conceived by M. E. P. Seligman (see Grasso & Stampa, 2006, 2008) – this presentation, offered by a psychologist who has clearly developed her own idiosyncratic simplified version of the approach, is truly disconcerting. Yet social media are saturated with similar proclamations, produced by licensed psychologists (again: authentic quotations, anonymized):

Enough with endless therapies! Center XY offers the only therapy capable of resolving all your psychological problems in just a few sessions.
 XYZ Psychotherapy is the integrated method that I have developed over more than 15 years of experience, combining strategic brief therapy, positive psychology, well-being psychology, psychosomatics, and mind–body approaches with ancient holistic self-healing practices to enhance therapeutic

effectiveness and guarantee concrete, lasting results. Unlike other approaches, it allows you to overcome anxiety, stress, and difficulties in a short time (without long therapies and without medication), thanks to immediately effective strategies, a focus on the here-and-now, and a wide selection of integrated techniques.

My approach is highly pragmatic and problem-oriented, so I do not focus on analyzing the past; instead, I try to understand the person's resources in order to help them solve their problem concretely and quickly. To this end I also assign homework to speed up the process: for example, for someone with self-esteem issues, I may prescribe what I like to call the 'strengths journal' so that the person can focus on their strong points and thus develop on more solid foundations. Daily journaling greatly accelerates the process and makes the session last not fifty minutes but an entire week: in this way, the person remains engaged in their growth even outside the session, thus enhancing the intervention […].

Urgency – alongside the oversimplification of psychological processes – has become a semiotic marker reproduced by social media, a discursive feature once absent from psychological culture, which traditionally grounded its identity in the defense of the time necessary to activate and develop processes of change that are not superficial but authentic precisely because they are deep and rooted in an epistemology of complexity. Only such an epistemology is capable of addressing the challenges inherent in intervening in mental life. Acceleration, therefore, becomes a new form of social alienation, as the philosopher and sociologist Hartmut Rosa (2015) has argued.

Social media may be the latest expression of the major semiotic revolution that began in the 1960s–70s with the expansion of mass communications, in which Jean Baudrillard prophetically saw the end of the social, marked by the implosion of meaning under the uncontrolled overload of information. What power once concealed through secrecy was now annulled through the accumulation of undecidable data, giving rise to what would later be called "post-truth".

Retaining this nihilistic potential, social media have completed that revolution by reversing its meaning and direction: the sense once lost in the top/down strategic falsification of centralized communication networks is today lost in the infinite bottom/up dissemination of posts and images circulating by the billions each instant, rendering impossible any discrimination between true and false, plausible and

implausible, fantasy and reality. The semiotic signature of the contemporary world has become irreducibly exhibitionistic: compulsively showing everyone – and no one – the most trivial events of daily life has become the religion of our time, and incessantly checking one's smartphone in search of markers of belonging to a virtual community has become a daily ritual.

How could this language fail to shape the public image of the profession, once psychologists began using social media to enter the marketplace?

Already several years ago (e.g., Levahot *et al.*, 2010; Taylor *et al.*, 2010), U.S. studies showed that the vast majority of psychologists (77%) and psychology trainees (81%) used social media without distinguishing between personal and professional profiles, paying little attention to the possibility that clients might gain access to strictly private information, potentially at odds with the theoretical and technical requirements of clinical practice.

There is no doubt that this "popular", somewhat *cheap* mode of professional functioning has brought significant financial benefits to Italian psychologists. Data from ENPAP, the national social security entity for psychologists, concerning the dramatic period marked by COVID-19 (2020-2022) and the rapid expansion of online psychological services, show striking increases in the average income of registered professionals; this will be discussed further in section (4). Yet something more must be said about psychologists' use of social media.

The public image of the profession is shaped in social consciousness, in tradition, and consequently in the Ethical Code, through the concepts of *decorum* and *dignity*. These are constructs that, on the one hand, broadly apply to all professions, and on the other hand possess specific modes of expression depending on the profession in question; moreover, they are subject to change – sometimes radical – over time. In the context considered here, the crucial factor is the culture of social media, whose language literally produces new modes of representing psychology, inevitably generating illusory expectations among the public and establishing a novel and implausible social mandate for the discipline (Grasso & Stampa, 2014).

Although "*decorum*" and "*dignity*" are often presented in Italian dictionaries as near-synonyms, it is useful here to emphasize their

distinction and complementarity, rather than their partial – if predictable – overlap.

In the use of the term *decorum,* the aesthetic dimension must be highlighted, referring to how one's conduct is perceived by others. In the use of *dignity,* the emphasis shifts to a more substantive dimension, involving the rights and duties of the person. Consider the two contexts in which it appears in the Italian Constitution: Article 3 ("All citizens have equal social dignity and are equal before the law…") and Article 36 ("Workers have the right to remuneration proportionate to the quantity and quality of their work and in any case sufficient to ensure a free and dignified existence for themselves and their families").

In the social media environment, the dimension of appearance seems to have entirely absorbed that of substance, to the detriment of demonstrable professional competence grounded in qualified experience, scientific publications, and language befitting the seriousness of the intellectual and ethical responsibilities intrinsic to professional work – and all the more so to healthcare professions. So much so that regulations governing publicly available information provided by healthcare professionals prohibit any "promotional" and/or "suggestive" characterization – prohibitions that are unrealistic and thus entirely ineffective.

Yet in a context where appearance is everything, aesthetics become subsumed under ethics: *decorum in appearance* becomes the sole rule safeguarding the profession's public image. Here one might recall the second and third of the twelve shades of meaning assigned to "*decoro*" in Battaglia's *Grande dizionario della lingua italiana* (1966): «conduct that ensures the esteem and respect of others; a sense and awareness of what is fitting»; and «behavior inspired by correctness, discipline, respect, courtesy, good breeding, and education». It is better, in this context, to remain silent about the ways in which psychologists sometimes interact publicly in social media comment threads, exchanging harsh jokes, insults, and sarcastic remarks with users, followers, and the inevitable haters and trolls.

To conclude this brief analysis, something may be added regarding "*dignity*" as it pertains to professions and to psychology in particular.

In Battaglia (1966), the most relevant meaning is the following:

The habitual and consistently upheld condition of moral honor and nobility, arising from a person's intrinsic and essential qualities, grounded in their behavior and bearing in social relations, their merits and standing; and, at the same time, the respect that such ethical exemplarity demands and elicits in others.

De Mauro's *Grande dizionario dell'uso* (2000) follows a similar line, whereas the more recent Simone dictionary (2010) retains only one definition:

The condition of moral nobility deriving from a person's standing and qualities, and the respect owed to them for such a condition and which they must also maintain toward themselves.

How these concepts may translate into appropriate professional conduct can only be entrusted to principles of self-regulation, which every professional has both the duty and the interest to cultivate in order to operate correctly. As has been observed:

From a linguistic standpoint, the vagueness that blurs the boundaries of meaning is not a limitation but a resource. It is what enables words to be flexible, adaptable, and responsive to the changing and ever-new needs for meaning within a human community. It is up to speakers not to shy away from dialogue so that words may – where necessary – be filled with content that is as widely shared and shareable as possible (Torchia, 2019).

As will be seen shortly, this collapse of competence models in the social media system – and the concurrent erosion of established standards of "*decorum*" and "*dignity*" in the psychological profession – is, together with the widespread lack of practical preparation (for which responsibility lies squarely with university training), a significant factor in the proliferation of various forms of unauthorized professional practice.

Critical Issue (3) – The Proliferation of the Unlawful Practice of Psychology

Let us take another step forward, keeping in mind the points examined thus far. Social media are teeming with offers addressing

problems that are typically psychological in nature, originating from individuals who are not psychologists. A few examples from Instagram:

Work-related anxiety? Dissolve any negative emotion in just 20 minutes. Discover the "Empty the Cup" method, based on a 1,500-year-old Tibetan practice!

"*I want to change my life and the lives of others!*". Become a Mental Coach – learn the only practical course based on 27 strategic pillars that will teach you how to be a Mental Coach and earn money by helping others". Control your emotions, build your happiness! Transform your fears and uncertainties into pillars of strength, and navigate toward inner harmony.

Discover the RebirthinLove® method to become a Spiritual Coach & Mentor […] You will learn how to integrate RebirthinLove® tools into your current work; how to develop your holistic practice to help an increasing number of people; and how to live in accordance with your Soul and fulfill your life purpose.

Enough with the quotations: in the end, they are all the same, and any one of them would suffice.

What matters for the present analysis is that (a) psychologists' decades-long disinterest in "generalist" psychological interventions and their excessive – if not exclusive – focus on specialization in psychotherapy; (b) the complete cultural and strategic disengagement of professional Boards until roughly a decade ago; and (c) today, psychologists' limited self-regulation in their own social-media communication – all of this has enabled the progressive occupation of vast market spaces by individuals who, without any training subject to public oversight, respond in the ways exemplified above to an emerging demand for psychological interventions. This demand is now recognized as far more widespread than was estimated even just a few years ago (a shift accelerated, of course, by the pandemic).

We have referred to "public oversight", which in Italy is exercised by the professional Regulatory Bodies, the public boards through which professions are organized and regulated. Their establishment is consistent with Article 33(5) of the Constitution, which requires passing a State Examination for access to what are properly defined as professional activities. And there is a reason the Constitution mandates a State Examination: the exercise of a profession entails a high degree

of autonomy and discretion in choosing methods and approaches to clients' problems. It therefore requires an equally high degree of responsibility – captured in the well-known expression "*science and conscience*" – encompassing both the technical and ethical dimensions of competence and performance.

It is essential to recall that Article 1176 of the Civil Code establishes that a professional service entails an obligation of diligence, not of outcome (see Posteraro, 2019). Unlike merchants, artisans, or producers of goods, professionals must be remunerated even when the result is not satisfactory to the client or service recipient. This makes their duty to provide technical and ethical competence beyond any conceivable doubt – and to deliver a maximally responsible performance – even more stringent.

However, the cultural landscape is rapidly changing, and certainly not in ways that protect the professions. Indeed, the most recent legislative trend has been toward assimilating them to other forms of service provision, for which an obligation of results is not taboo but the rule.

This is one of those cases in which European legislation – binding on the Italian legal system – is misaligned with the Constitution of the Italian Republic. And because the Constitution cannot be easily amended, the Legislature has begun to improvise, introducing innovations surreptitiously, so as not to violate constitutional principles too visibly. Law 4/2013 is the clearest example: it created, within the Ministry of Economic Development, a registry of "professions" not organized in public professional regulatory bodies. This is effectively equivalent to saying that, lacking a professional regulatory body, access does not require passing a State Examination – and thus they should not even be called "professions". It is a simple syllogism: if, in order to practise a profession, one is required to have passed a State Examination (as indeed provided for by the Constitution of the Italian Republic), then the activity carried out by someone who has not passed such an examination cannot be regarded as a profession.

The UNI standardization/certification body is tasked with "legitimizing" the private Associations representing these pseudo-professions through highly questionable procedures – particularly in relation to market-opening attempts by the various categories of counselors, coaches, mentors, and similar figures (see Conte & Stampa, 2021).

Thus, in defending the professions that they formally organize and

protect, the Boards are "fighting uphill", forced to contend with a law that – unless declared unconstitutional – remains fully in force. The spirit of the trend emerging within the European Union is well represented in its Directives (notably Directive 2006/123/EC) and Recommendations, which promote easier access for young people to the labor market, including by shortening training periods, liberalizing regulated professions, and gradually transforming them into something akin to "one-person companies", facilitated by reduced regulatory constraints in the name of free competition.

Law 4/2013 is the lever through which private associations of counselors, coaches, mentors, and similar figures – often through distorted interpretations – claim to have obtained public recognition, which, through a kind of "halo effect", would extend from the association to its individual members.

Should we add that a large portion of the training of counselors, coaches, mentors, and similar figures is provided primarily by psychologists? Neither disciplinary actions nor the few (and often mitigated) court rulings obtained by the Boards have so far deterred them: civil sanctions against instigators and trainers have frequently been reduced or overturned on appeal; criminal prosecutions rarely succeed because the unlawful practice of psychology is difficult to prove unequivocally. When things go well, offenders are convicted of fraud – not of the unlawful practice of a profession.

In short, we are confronted with a permanent "state of war" – cultural, commercial, and judicial – in which counselors, coaches, mentors, and the like can rely on the active complicity of many who should, instead, be standing on the opposite side of the barricade. But how can the psychological profession hope to prevail in this conflict when it so often presents itself publicly using the same style, the same keywords, and the same clownish demeanor as its opponents?

Critical Issue (4) – The Challenge of Online Counseling

The next two sections will be brief, limiting themselves to presenting the final critical factors we intend to examine – factors associated with the most recent developments in the profession, driven by a rapidly and continuously evolving technological landscape.

The 2020–2022 pandemic enhanced and widespread online psychological consulting practice, which, until 2020, had often been viewed with skepticism and discouraged, despite its great usefulness in specific situations: Italians living abroad; individuals unable to leave their homes due to disability or because of the very psychological problems for which they were seeking help; and residents of marginal areas poorly connected to the cities where psychologists' offices are located. Since the 2020–2021 pandemic, psychologists increasingly work from their homes or studios via Zoom, Google Meet, or other videoconferencing platforms, offering forms of counseling that are progressively de-localized and "dematerialized".

Not all clients/patients accept this modality willingly, yet its convenience is being increasingly appreciated, especially in large metropolitan areas where, until only a few years ago, the choice of a psychological consultant was based on geographic proximity. Indeed, both professional Boards and online service-presentation systems provided information on the availability of psychological services through Google Maps: the long-imagined but never formally instituted "neighborhood psychologist" effectively emerged in the same topographical maps used for locating restaurants, auto repair shops, or dance schools.

Accustomed – due to the pandemic – to remote working, individuals quickly came to accept the idea of meeting virtually with psychologists whose assistance they felt they needed. Gradually, problems that initially appeared serious and unsolvable have been overcome: the often poor quality of Internet connections; the fact that clients/patients may not be alone at home and may feel the symbolic, if not concrete, influence of the physical presence of relatives or cohabitants (it is not uncommon for patients to conduct their sessions from inside their cars, an extension of the home already noted by Roland Barthes in *Mythologies*, 1957); and the emerging tendency not to keep a fixed day and time for sessions, but to adopt an increasingly "flexible setting" at least with regard to strictly practical aspects – though such flexibility inevitably affects emotional dimensions as well.

At this point, everything has changed. In the past, finding potential clients/patients in one's neighborhood required primitive forms of advertising, such as leaving business cards on the balcony of a pharmacy or in the waiting room of a general practitioner. Now, digital

marketing expands with all its "capture" tactics, largely based on social media – with all the characteristics examined in the previous two sections.

But to this already powerful reinforcement of new, and often questionable, forms of online self-presentation and self-promotion by psychologists, another element was soon added: platforms.

Thousands of psychologists have entered – and continue entering – these systems for the recruitment and distribution of first-level clinical assistance and online psychotherapy.[10] These systems operate through approaches heavily shaped by a commercial mentality, corresponding to innovative practices that once again show little regard for the decorum and dignity of the profession, and for its cultural differentiation from the unlawful imitations discussed in the previous section.

Clients/patients are assigned according to a strict criterion: they must reside in cities different from those of the consulting psychologist, so as to prevent the possibility of being redirected – at least physically – into the psychologist's private office. Initial consultations are free of charge, and psychologists are instructed to "hook" and subsequently "retain" the client/patient. Fees are modest (currently around €50, of which 30% goes to the platform; the consultant receives roughly €35 gross per session), but compensated by a high volume of working hours. This model can allow – especially for younger professionals – an annual gross income of €50,000–60,000, assuming 6–8 hours of actual work per day, 24–26 days per month, for approximately 10 months per year. At least in theory: many hours, particularly at the beginning, are devoted to free consultations, and – according to accounts we have received – the turnover of clients/patients is rapid. Over time, however, the situation stabilizes, and a panel of roughly thirty regularly paying clients becomes relatively secure. Disengaging from the platform is costly: a fee of several hundred euros must be paid for each client/patient under care at the moment of withdrawal.

But what is the substantive nature of the professional engagement between psychologists and these platforms? On the surface, and from

[10] The UnoBravo platform alone reported on Instagram, in mid-October 2025, "over 8,500 practitioners" – about one thousand more than in the same period of the previous year – "5 million online sessions delivered", "over 400,000 people supported", and "more than 20 psychotherapeutic orientations' offered".

a civil-law perspective, the arrangement appears to be a freelance contract. In reality, it is a form of quasi-subordinate labor disguised as self-employment, in which the employer is a dominant contracting party who strongly constrains thousands of weaker contractors, effectively placing them in a position of dependency.

There is no doubt that these platforms constitute a colossal business. It is enough to note that UnoBravo, emerging from nothing, reached a valuation of several tens of millions of euros in just four years. And there is no doubt that they provide, in very short timeframes, work opportunities for psychologists who would otherwise take years to achieve comparable levels of income. But equally, there is no doubt that their market approach is bold and entirely counter to the requirement that the psychological profession present itself to the public in ways aligned with legal and ethical mandates – not to mention the collective reputational damage that favors the spread of unlawful practice through the erosion of semiotic differentiation.

But what is about to happen next? We briefly address this (for now, it is impossible to do more) in the following section

Critical Issue (5) – The Challenge of Generative Artificial Intelligence

For some time now, several platforms have begun to impose a new requirement on the psychologists they employ – or rather, not an active requirement but a passive one. This consists in the remote recording of sessions through software installed and linked to the practitioner's account on the platform, with the stated (and patently implausible) purpose of monitoring their work in order to assess its quality and effectiveness. As if such a form of surveillance did not constitute a substantial constraint on psychologists' freedom to operate under conditions "that do not compromise their professional autonomy […] in the choice of methods, techniques, and psychological tools, as well as in their use", as stipulated in Article 6 of the Ethical Code of Italian Psychologists. And as if it did not also represent a significant constraint on the assisted person: who among us, once aware of being recorded, speaks with the same calm, spontaneity, and fluency as when certain that no recording is taking place?

Platform managers are increasingly explicit in acknowledging that these recordings are intended to be processed with AI software. How could one doubt that the true objective is to train AI systems to provide assistance first alongside, and later in place of, human psychologists?

In some countries, AI-based "psychological support" systems are already circulating online via mobile apps. Wysa, Woebot, and Replika are chatbots that offer interactive "conversations" (if an exchange between a human communicating lived experience and a machine computing signifier occurrences and associations can meaningfully be called a "conversation" in the cultural sense traditionally assigned to the term) for the purpose of emotional support. A rapidly expanding literature highlights both the positive potential of such chatbots for anxiety–depression symptomatology (particularly short-term remission of mild symptoms) and their limitations over time (follow-up periods are inevitably too short), as well as possible risks (semantic misunderstandings, and the induction or reinforcement of self-harming behaviors). Overall, however, research remains unreliable due to small sample sizes, uncertain methodology, and – most critically – the biases produced by the vested interests of chatbot developers conducting outcome studies on their own products.

While some recent cross-sectional studies in the anglophone area may be considered more stimulating – e.g., Sweeney *et al.* (2021); Tulk Jesso *et al.* (2022); Ayers (2023); Li, Theng & Fu (2023); Kuehn (2023); APA Member Services (2024); Thakkar, Gupta & De Sousa (2024); Feng *et al.* (2025); Evans (2025) – Italian research on the topic remains largely undeveloped. Meanwhile, the latest report by Save The Children Italia (2025) indicates that 92.5% of adolescents aged 15–19 use AI tools (nearly double the proportion of adults, at 46.7%). Of these adolescents, 41.8% (from a national sample of 800 individuals aged 15–19, compared with an additional representative sample of the Italian population aged 18–74, based on 1,359 interviews) report having turned to AI chatbots for help when they "felt sad, lonely, or anxious"; more than 42% sought advice on important decisions concerning romantic relationships, school difficulties, or family issues. Such figures signal an objective form of "professional competition" for psychologists, who would do well to reflect on them and identify potential pathways for use, integration, or differentiation.

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The ethical and legal aspects of this issue, in the context of Italian professional psychology, also merit attention.

To begin with, there is still no regulatory framework applicable to the use of AI as a tool for psychological support. Compliance with Law 56/89, which governs psychological activities in Italy, implies that an assistance chatbot cannot be considered anything other than a self-help tool entirely detached from professional responsibility. A psychologist could not simply design and release such a chatbot on the market, as Article 3(4) of the Code of Ethics holds them responsible for their professional actions and their "predictable direct consequences". Any negative effects on a chatbot user's psychological balance, for which a causal link with the "conversations" could be demonstrated, would be immediately attributable to the professional who created it. Such a designer would, moreover, have deliberately – and with a remarkable degree of imprudence, if also under the weight of inevitability – renounced any control over the interaction between the software they built and its end-users.

The issue of collecting, protecting, processing, and storing sensitive data provided by assisted persons whenever a professional employs AI tools in their activity is the subject of intense debate, though its boundaries remain unclear. Who can guarantee, for the professional even before the client, adequate control over this process? An AI system could make any lawful or unlawful use of this mass of information without anyone becoming aware of it. The recent emerging regulations addressing these matters remain confused and far from offering even minimal guarantees[11]. As is evident, we are at an early stage, and no

[11] Law No. 132/25, Scientific Research and Experimentation in the Development of Artificial Intelligence Systems in the Healthcare Sector, Article 8: "(1) The processing of data, including personal data, carried out by public and private non-profit entities, by the Scientific Institutes for Research, Hospitalisation and Healthcare (IRCCS) […] as well as by private entities operating in the healthcare sector within research projects in which public and private non-profit entities or IRCCS participate, for the purposes of scientific research and experimentation in the development of artificial intelligence systems for the prevention, diagnosis and treatment of diseases, the development of pharmaceuticals, therapies and rehabilitative technologies, the creation of medical devices – including prostheses and interfaces between the body and assistive instruments supporting the patient's condition – public health, personal safety, health and healthcare security, as well as the study of human physiology, biomechanics and biology, including in non-healthcare contexts, insofar as

one is prepared to make predictions even five years ahead. Nonetheless, AI is already far more advanced than the profession's current capacity to govern the research, implementation, and development processes of these emerging forms of consultation – which will undoubtedly spread in our context sooner than we realize their actual implications.

necessary for the establishment and use of databases and foundational models, are declared to be of significant public interest pursuant to Articles 32 and 33 of the Constitution and in compliance with Article 9(2)(g) of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016. (2) For the same purposes, without prejudice to the obligation to provide information to the data subject – which may also be fulfilled through a general notice made available on the data controller's website – and without requiring any further consent from the data subject where originally mandated by law, the secondary use of personal data stripped of direct identifying elements, including data belonging to the categories referred to in Article 9 of Regulation (EU) 2016/679, is always authorised for the entities referred to in paragraph 1, except in cases where knowledge of the identity of the data subjects is unavoidable or necessary for the protection of their health. (3) In the areas set out in paragraph 1, or for the purposes referred to in Article 2-sexies, paragraph 2, letter (v), of the Personal Data Protection Code (Legislative Decree No. 196 of 30 June 2003), the processing of personal data – including data belonging to the special categories referred to in Article 9(1) of Regulation (EU) 2016/679 – for the purposes of anonymisation, pseudonymisation or synthesisation is always permitted, subject to prior information being provided to the data subject pursuant to Article 13 of Regulation (EU) 2016/679. Such processing is also permitted when carried out for the study and research on athletic gestures, movements and performance in sport in all its forms, in accordance with the general principles set out in this Law and with due regard for the economic exploitation rights pertaining to competitive sporting activities held by their organisers. (4) The National Agency for Regional Healthcare Services (AGENAS), having obtained the opinion of the Data Protection Authority and taking into account international standards as well as the state of the art and of technology, may establish and update guidelines for procedures relating to the anonymisation of personal data referred to in paragraph 3 and for the creation of synthetic data, including with respect to different data categories and processing purposes. (5) The data processing activities referred to in paragraphs 1 and 2 must be notified to the Data Protection Authority, indicating all information required under Articles 24, 25, 32 and 35 of Regulation (EU) 2016/679, as well as expressly indicating, where applicable, any entities designated pursuant to Article 28 of the same Regulation. Such processing may commence thirty days after the aforementioned notification, provided that no blocking order has been issued by the Data Protection Authority. (6) The investigative, prohibitory and sanctioning powers of the Data Protection Authority remain unaffected". As is evident, this legislative effort has resulted in provisions that are exceeding complex both to interpret and to apply.

It is possible that AI-based psychological support systems will absorb the multitude of proposals – whether originating from psychologists or from counselors, coaches, mentors, and similar practitioners – based on "tips", advice, exercises, guided autosuggestion, and the like. This seems, in fact, to be the prevailing trend in the distortion of psychology that multiple social actors are currently driving. While the *New York Times* publishes an extensive and alarmed feature titled "*Thinking Is Becoming a Luxury Good,*"[12] in Italy a former government minister launches a new psychological assistance platform, "*Stop Thinking*"[13] aligning with the cultural trajectory of a well-known psychiatrist, author of best-selling works such as *Love and Don't Think* (Morelli, 2018) and *Close Your Eyes and Don't Think* (Morelli, 2024). Non-thinking thus appears to be the new frontier of a paradoxical anti-psychological psychology that conforms to the strategic designs of multinational AI corporations – converging with them on economic grounds that are quite clear, yet culturally and politically still opaque. If psychology – particularly clinical psychology – grounded in the development of reflective capacity has deep democratic ideological roots in twentieth-century authors (Stampa, 1993), the promotion of non-thinking clearly signals a turn toward an authoritarian drift in the management of public life that, originating in the United States, is also spreading through Europe, propelled by AI systems. A population of non-thinkers is an ideal breeding ground for dictatorships (Pennella, 2019), and the contemporary Western landscape does not lack initiatives more or less overtly aligned with such aims.

Setting aside this broader historical context, let us return to the living reality of our profession. It is conceivable that this paradoxical "anti-psychological psychology" – not exactly the death of psychology, but rather a "zombie-psychology", seeming a living dead – may partially replace human psychologists on online platforms.

We may be facing an epochal confrontation within psychology. In this context, there may also emerge a renewed and revitalized

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[12] https://www.nytimes.com/2025/07/28/opinion/smartphones-literacy-inequality-democracy.html, July, 28, 2025.
[13] Cfr. https://www.facebook.com/watch/live/?ref=watch_permalink&v=721427251031384. Danilo Toninelli was ministry for Infrastructure and Transport 2018-19, Conte Administration

psychology grounded in the epistemology of complexity and in a serious capacity to explore mental life, cultivated through the rigorous training of a new generation of professionals equipped with a substantive psycho-theoretical culture rather than empty techniques devoid of theory.

For this to occur, however, hoping is not sufficient. Universities, professional Orders, and scientific and professional associations must commit themselves actively to this work.

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Taking Care of the Mental Health:
A Social Community Issue

*Santo Di Nuovo**

Abstract

The article comments on the Italian "National Action Plan for Mental Health", suggesting a truly transdisciplinary approach that enhances all the disciplines and professionals involved, ensuring the methodological, organizational, and financial aspects needed for its concrete implementation.

Applying the transdisciplinary approach, "Project communities" are needed to build and implement a shared project, in which various social actors participate in planning and in integrated operational strategies.

The mental health services should have as their objective "health" in the broadest sense, i.e., a state of psychophysical and social well-being and a good quality of life, to be improved within social contexts.

Overcoming the ancient dualism between the biological and psychosocial approaches, the principle of "One Health" requires adequate support by the psychological profession to promote welfare and well-being, placing "the mind at the centre of life", both at individual and social levels.

Keywords: Health, transdisciplinarity, well-being, community psychology.

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Mental Health Care: Toward a Transdisciplinary Approach

The "National Action Plan for Mental Health" (hereinafter: The Plan) is based on the premise that mental health and mental illness are social phenomena – not just individual or small group phenomena – and that an adequate response must be given at the social level to the well-being needs of the globalized and interconnected community in our era. Mental illness causes distress, which the Plan intends to address at all levels, not only therapeutic but also preventive. This requires the specialized and coordinated intervention of diverse professionals trained in related disciplines, which are strongly interconnected in content and purpose, even if they are distinct in their methods and professional practices.

Mental health care concerns areas such as addictions, justice for adults and minors, and family crises, which do not fall within the scope of psychiatric illness in the traditional sense. The Plan confirms that youthful identity crises, relationship problems, social isolation, and new addictions should not be pathologised and require not only medical but also educational and social responses. Therefore, sociologists, psychologists, educators, rehabilitation professionals, as well as economists and social policymakers, are of interest in addition to psychiatrists. All these professionals must be involved in defining what mental health is, and how it is promoted in different social contexts.

Many theorists and researchers from the various disciplines mentioned above have contributed to consolidating shared frameworks for the diagnosis and treatment of psychopathology in non-biological terms. In this sense, psychiatrists oriented to phenomenology, such as Jaspers, Binswanger, and in Italy Callieri, Cargnello, and Borgna (for a review: Di Nuovo 2009, 2024), as well as scholars of the human sciences such as Maslow, Rogers, Foucault, Deleuze, have contributed to developing theories and methods that can be profitably applied to research and the psychological, educational, and rehabilitation professions.

However, contrary to what is reiterated in the Plan, it is not uncommon to find services in which psychologists, educators, and sociologists are considered a useful but not essential accessories in the management of services. In particular, in some services psychologists are considered specialists in psychometric diagnosis through testing, thus

diminishing a role that deserves to be much broader and more comprehensive – as the Plan recognizes in several parts, for example, by promoting psychologists in "primary care" and other sectors covered by the text.

To avoid these risks, appropriate methods for integrating the various professional skills should be defined, at the applicative and organizational level, to achieve the common objectives outlined in the biosocio-psychological "One Mental Health" model, thus transforming it into a truly global "One Health System."

The history of psychopathology, and the therapeutic response to it, confirms that the dysfunctional lack of integration between different mental health disciplines originates not at the theoretical and scientific level, but at the professional level. Therefore, it is at the practical level that the fundamental principles well-recognized by the Plan must be translated, with a fully defined and articulated methodological project.

The need for a multidisciplinary approach, as defined by Morin (Nicolescu, 2008), should be affirmed. In traditional *interdisciplinary* research, each science collaborates while remaining within its own disciplinary boundaries. Psychiatry, psychology, and sociology combine their methodologies to obtain highly original knowledge with significant applied implications. *Knowledge communities* are thus built, which form the foundation for connecting research, applications, and training. By sharing and applying this knowledge in multidisciplinary services, multiple professionals create *action communities*. Mental Health Services based on a multidisciplinary approach implement this approach, in which each discipline contributes individually to a common effort. The multidisciplinary approach is effective when different professionals intervene at different times and with different objectives; but it becomes less effective when the objectives cannot be fragmented and have to be shared a priori in a common project.

In more complex cases – such as health services in the broadest sense of the term – a further step is necessary. *Project communities* are also necessary, in a "transdisciplinary" approach, which transcends individual disciplines, and disciplinary focus itself, to build and implement a shared project, in which various social actors participate in the planning and in the joint action, working together with integrated operational strategies. In Bernstein's (2015, p. 1) words, «Transdisciplinarity today is characterized by its focus on 'wicked problems' that

need creative solutions, its reliance on stakeholder involvement, and engaged, socially responsible science».

In transdisciplinary integration each discipline maintains its own specificity, without losing its identity, but together with other disciplines it develops targeted interventions that are verifiable in terms of effectiveness. This effectiveness must be verified not only at the level of social policies, but also at the scientific level, intrinsically linking research and application, using research models that continuously verify the effects of the intervention, through longitudinal strategies, and qualitative tools. Assessment and intervention should also be based on «transdiagnostic factors» (Aldao *et al.*, 2010; Benzi *et al.*, 2023; Newby *et al.*, 2016).

Transdisciplinary and transdiagnostic methodologies must be shared in a system without stable boundaries between disciplines (Piaget, 1972), which is not easy to achieve if scientific systems establish rigid barriers between scientific models and the professionals who apply them.

At the organizational level, current services generally involve a combination of skills and actions, rather than truly integrated ones. Implementing a transdisciplinary approach requires negotiation to define objectives and methods, in synergy with the stakeholders who represent social demand, solicit intervention, and verify it.

The Plan provides a valid framework, but transdisciplinary strategies and tools for planning and scientific verification should be further articulated in operational guidelines to be applied uniformly across regional and local contexts. This would address what the Plan summarily states, echoing the Lancet Psychiatry Commission's proposal, which «analyses how to integrate research with real-world implementation, place equity at the core of mental health interventions and research, apply a complexity science perspective, expand study models beyond randomized clinical trials, and enhance transdisciplinarity in various initiatives» (Plan, p. 96).

From "Care" to "Caring"

The transdisciplinary approach allows to fulfil the fundamental role of mental health services: they cannot focus solely on the treatment of

illness, its diagnosis and treatment (be it pharmacological or psychological), limiting themselves to individuals, families, or small groups. Instead, they must have as their objective "health" in the broadest sense within the social context.

This general definition of health is recognized by the Plan, citing Article 32 of the Italian Constitution, which defines health as a "fundamental right of the individual and a collective interest" and as such must be protected by the State, which for this reason too is defined as a "social" State. In implementing the constitutional principle, the State and the Regions – without inequalities or disparities between them – are required to guarantee "Essential Levels of Care", the services deemed most appropriate and effective for the health needs of citizens, in compliance with essential criteria such as the dignity of the human person, the expressed need for health, homogeneity and equity in access to care, and the quality of care.

According to the well-known definition of the World Health Organization, taken up by the Plan, health consists not merely in the absence of disease, but in a state of psychophysical and social well-being and a good quality of life.

All these principles are stated in the preamble to the Plan. But in the articulation of interventions, it seems to take a different direction by underestimating the phenomenological attention to the more global "meaning" of mental health problems, which are the cornerstone of prevention. Beyond the statements of principle (the term "prevention" is among the most frequently repeated in the Plan), the practical application prevalently reproduces the logic of treatment intervention addressing the manifestations of distress.

Psychological well-being, which is the goal of the right to health, was defined by Rogers (1961) as "full functioning", that is, the complete activation of psychological and social functions that allow an individual's active adaptation to their environment, and the resulting sense of subjective satisfaction. Understood in these terms, well-being not only prevents mental illness and reduces languishing, the feeling of emptiness in life and a lack of hope, but also promotes a state of flourishing, a feeling of growth and prosperity: what the Anglo-Saxons optimistically call "happiness".

Treatment means not only repairing what is broken, but also caring for the whole person who has a dysfunction, or is at risk of

having one. This defines prevention, often cited but rarely implemented for economic and organizational reasons. The obstacles to achieving the objectives set out in the Plan are not resolved, nor can be resolved by maintaining the financial principle of "equal resources", that is, without additional funding to really achieve what is theoretically desired.

Psychology in the "Health System"

To achieve overall psychophysical well-being, health care should be multidimensional and therefore multi-professional, requiring medical, psychological, social care, and institutional interventions. To be globally effective, from the transdisciplinary perspective discussed above, these interventions should be planned and coordinated within a network, not fragmented among different professionals, and among the different areas addressed by the Plan: childhood, adolescence, and family, deviance and legal responses, traditional and new addictions, social and work inclusion, risk and safety, and digitalization.

The Plan overcomes the ancient and harmful dualism between the biological and psychosocial approaches to health, recognizing that social dimensions and biological grounds are inextricably linked and continuously interact in the evolution of the individual and the species. This is a truth always recognised by the psychosocial sciences. Morin wrote in 1982 that all sciences, including physical and biological ones, are social. Recent social neuroscience has highlighted how consciousness realises its biological potential in epigenetic development, through relationships with the physical and social environment.

Therefore, improved health can only arise from the interaction between biological mechanisms and psychological and social dynamics: not in the sense that they are two separate entities that must be joined (the old Descartes' error...), but rather that they are two sides of the same reality: precisely, the body-mind unity 'extended' throughout the world, through the embodied and enacted cognition (Clark & Chalmers, 1998; Murphy Paul, 2021; Rowlands, 2013).

Having affirmed the principle of "One Health" we should be consistent in implementing it, defining the organizational aspects (and related resources) that address the problems of current and potential

hardship at their root, in different contexts: education, family, work, leisure, and social media use.

A clear example of the need for "One Health" is the study and intervention on stress, which alters the well-being of individuals and social groups. Its reduction is the fundamental goal of preventing physical and psychic diseases. Stress has genetic and epigenetic aspects (for example, those involving the immune system), biological, emotional-affective (psychophysiological arousal), cognitive (worry), relational (in family, and social groups, including media), and institutional (e.g., work-related distress).

The embodied mind immersed in social contexts creates a new dimension of study and research, as well as applicative interventions, of great relevance and timeliness.

Psychologists deal with the social mind and its health in an integrated manner, combining diverse aspects and approaches to create interventions that are simultaneously:

- *comprehensive*: caring for the persons in their mind-body unity, in the relationships with the context as a promoter of health or, conversely, of distress and discomfort;
- *specific*: adapted to the individual case, not 'standardized';
- *stable:* not extemporaneous, nor episodic;
- *multimodal*: going beyond the specialization of objects and techniques;
- *multidimensional*: addressing formative, rehabilitative, preventive aspects.

The effectiveness of psychological approaches is supported by numerous scientific studies, although the search for empirical evidence uses methods and tools different from those typical of laboratories and randomized clinical trials (Chien *et al.*, 2024; Schmidli *et al.*, 2020; Victora *et al.*, 2004). Community psychology's typical approach is both clinical and social, removing psychological interventions from their purely diagnostic and therapeutic dimensions and refocusing them on the context as a promoter of positive or negative epigenetics, and consequently of well-being or distress (for a review of research methods: Javdani *et al.*, 2023; Stevens & Dropkin, 2019).

Since 2017, the psychology profession in Italy has been under the supervision of the Ministry of Health, like doctors and paramedical personnel. This has fully integrated psychologists into healthcare

services, but some critics fear that this could lead to a "sanitization" of psychology. Instead, it offers opportunities to better contribute to the management of "health" in its broader sense. The right to health and well-being – as pursued in the multidimensional approach mentioned above – is realized in various fields of the Healthcare Service:

- in individual and families care, promoting psychological resilience as well as the recovery of global health;
- in school settings, to foster positive educational and interpersonal relationships, and prevent marginalization, or bullying, of those who are "different";
- in workplaces and organizations: for example, to avoid stress and burnout, going beyond assessing work-related stress with solely, or primarily, physical indicators;
- in the use of both traditional and new technologies, to prevent potential addictions to video games, gambling, cybersex, or even excessive and indiscriminate use of social media.

The psychology profession therefore promotes health and well-being placing "the mind at the centre of life", and reducing the impact of mental disorders on the community. This also serves to reduce the costs of pathologies, not only socially but also economically: there is data and scientific literature to support this (e.g., Lazar, 2014). If, as the data demonstrate, psychological treatment is indeed an "epigenetic drug" (Stahl, 2012; Massoni, 2024; Syed & Zannas, 2021), investing in psychology would be beneficial for society as a whole.

Given that psychological well-being and the perception of a good quality of life are the goals of comprehensive health, as the Italian Constitution requires and psychological science confirms, it follows that these goals can be pursued through the rules and consequent organization that the welfare state must ensure. This should be done without opportunistic savings in people and resources that risk undermining the good principles and compromising their practical implementation.

If it's true that "There is no health without mental health", is also true that mental health is part of the "general health" of individuals and society. The National Action Plan for Mental Health – in the spirit of the One Health approach – can become a "National Action Plan for Health and Well-being". Within it, all disciplines involved in "caring" for people, beyond the more or less limited spaces assigned to them

by the current Plan, can become essential promoters of welfare, assuring scientifically based skills coordinated from a transdisciplinary perspective, to offer them to the social community in an appropriate and coherent manner.

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The National Action Plan for Mental Health 2025-2030: Between Innovation and Continuity. A Psychological Perspective

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Abstract

The National Action Plan for Mental Health (PANSM) 2025-2030 marks an ambitious effort to reshape Italy's mental health system in response to new social and clinical challenges. Drawing on a psychological and professional policy perspective, this article critically examines the Plan's conceptual and operational structure. While the document affirms progressive principles such as a life-course approach, community-based integration, and the biopsychosocial model, its implementation proposals often revert to a traditional, medically dominated logic. This tension between innovation and continuity risks undermining the transformative potential of the Plan and perpetuating long-standing structural imbalances in the mental health system. A stronger recognition of psychology as a key discipline in prevention, early intervention, and community health is essential for achieving the Plan's stated goals.

Keywords: National Action Plan for Mental Health, psychology in primary care, community mental health, biopsychosocial model, professional policy, integrated care.

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Introduction

The publication of the National Action Plan for Mental Health 2025-2030 (*Piano di Azione Nazionale per la Salute Mentale* 2025-2030, PANSM) represents an important milestone in the evolution of Italy's mental health policy (Ministero della Salute, 2024). Coming after years of fragmented governance, regional inequalities, and increasing social distress, the Plan aspires to consolidate a renewed vision of public mental health capable of addressing the complexity of contemporary needs. The document arises in a context profoundly shaped by the COVID-19 pandemic, which exposed the fragility of existing care systems and highlighted the necessity of accessible, integrated, and psychologically informed responses to individual and collective suffering (World Health Organization, 2021). The Plan's rhetoric is promising. It speaks of prevention, proximity, and integration; it endorses a life-course perspective and a biopsychosocial paradigm; it invokes participation, community engagement, and evidence-based practices (WHO, 2021). Yet, as often happens in public policy, the distance between vision and implementation becomes apparent when one examines its operational structure. Despite its progressive language, the PANSM seems to reproduce patterns of medical centrality, with the Department of Mental Health (*Dipartimenti di Salute Mentale*), where psychiatric care constitutes the primary mandate and the presence of other professional figures (e.g., psychologists, social workers, educators) is complementary and integrative, remaining the undisputed axis of governance and intervention.

This commentary explores such inconsistencies, considering their implications for professional psychology and for the broader objective of promoting a public mental health culture grounded in prevention and social inclusion (Salvatore & Cordella, 2023).

Strengths of the Plan

It is important to acknowledge that the PANSM introduces several valuable conceptual orientations. First among them is the adoption of a life-course approach, which explicitly links childhood, adolescence, adulthood, and ageing within a coherent framework of mental health

promotion (Ministero della Salute, 2024). This orientation reflects an increasing awareness that well-being and vulnerability are not confined to specific clinical moments but are distributed across the developmental trajectory of the individual. In emphasizing early detection and timely intervention, the Plan aligns with international trends that seek to overcome the chronic underinvestment in prevention (WHO, 2021). Equally commendable is the explicit recognition of the biopsychosocial model. Moving beyond a reductionist medical framework, the Plan acknowledges the interplay of biological, psychological, and social determinants of mental health. This conceptual shift resonates with the ethos of community psychology and public health, which interpret mental suffering as an emergent property of social contexts, life events, and relational systems, not merely as an individual pathology (Tansella & Thornicroft, 2009). Another positive element lies in the reaffirmation of territorial and integrated care. By situating the Houses of Community (*Case della Comunità)* as centers for accessible, low-threshold services, the Plan echoes the vision of proximity care that was central to the de-institutionalization movement following Law 180 (AGENAS, 2022). It recognizes that the promotion of mental health cannot be separated from the networks of daily life such as schools, families, workplaces, and local communities. Moreover, the inclusion of evaluation and outcome assessment as necessary components of clinical practice suggests an awareness of accountability and quality improvement (WHO, 2022). These premises, taken together, indicate that the Plan aspires to a modern, socially responsive model of mental health governance. However, the strength of these conceptual foundations depends entirely on the consistency with which they are translated into operational measures.

Critical Issues

A close reading of the PANSM reveals a persistent discrepancy between its declared principles and its organizational prescriptions (AltraPsicologia, 2024). The most evident of these is the continued predominance of a medical and psychiatric logic. Although the introductory sections underline prevention and integration, the operative chapters revert to a service architecture centred on the *Dipartimenti di Salute Mentale* and their clinical hierarchies. This choice risks marginalizing

the contribution of psychology, social work, and education, disciplines that are essential for translating the biopsychosocial model into practice. The result is a paradox: a Plan that speaks the language of innovation but structurally reproduces the same frameworks that have limited innovation in the past. The underrepresentation of psychology in the national health system remains a major concern. The Plan itself reports that only 7.2 percent of territorial mental health activities are psychological or psychotherapeutic (Ministero della Salute, 2024). This imbalance reflects not only a shortage of personnel but also an institutional underestimation of the psychologist's role in prevention and early intervention. The consequences are visible: growing waiting lists, overreliance on pharmacological treatment, and inadequate responses to mild and moderate distress, conditions that could be effectively managed within primary care by qualified psychologists (AltraPsicologia, 2024). The ambiguity surrounding the position of the primary care psychologist further exacerbates this problem. On one hand, the Plan locates this figure within the *Case della Comunità*, consistent with the *Decreto Ministeriale 77/2022* and regional best practices such as those developed in Emilia-Romagna (AGENAS, 2022). On the other hand, it simultaneously asserts that the first level of intervention should be fully integrated into the *Dipartimenti di Salute Mentale*. Such wording risks reabsorbing the psychologist into the psychiatric domain, thereby undermining the autonomy, accessibility, and preventive mission of primary care psychology. The potential outcome would be the re-medicalization of psychological distress, contrary to the Plan's declared intention to promote well-being and early care. Another area of concern is the reference to task shifting and task sharing. While collaborative practice is essential in complex health systems, the way these concepts are presented in the Plan lacks sufficient clarity and safeguards. Without precise definitions of professional boundaries and responsibilities, task shifting may lead to the delegation of psychological tasks to inadequately trained personnel, with negative implications for service quality and patient safety (WHO, 2021). True interprofessional collaboration requires mutual recognition of competencies, not their dilution. The implementation of the Stepped Care model also appears inconsistent. The Plan invokes this framework, particularly regarding the treatment of depression, but then structures it around medical and pharmacological hierarchies, minimizing the role of psychological therapies at the lower levels (NICE, 2019).

This interpretation contrasts with the NICE guidelines, which place psychoeducation and psychotherapy at the foundation of the stepped approach. The result is an inversion of priorities that risks transforming an evidence-based model into a bureaucratic schema disconnected from clinical reality. Beyond these structural issues, several important thematic areas receive insufficient attention: psychological support in hospitals, emergency and disaster psychology, gender-based violence, migration, poverty, and the psychological aspects of work and organization. The Plan also overlooks the transformative potential of digital innovation and artificial intelligence in promoting accessibility and personalization of care (WHO, 2022). In neglecting these domains, it fails to engage with many of the most urgent psychological challenges of contemporary society.

The Campania Experience: A Pioneering Model of Primary Care Psychology

An important example of regional innovation in Italy is represented by the experience of the Campania Region, which has played a pioneering role in the establishment of primary care psychology. Campania was the first Region in the country to activate the Primary Care Psychology service (*Servizio di Psicologia di Base*, Regional Law No. 35 of 3 August 2020), formally integrating psychological care within the public health system and anticipating the organizational principles later codified in Ministerial Decree 77/2022. This strategic choice was supported by a dedicated investment of €32.5 million from the National Programme for Health Equity (*Programma Nazionale Equità nella Salute*, PNES), ensuring the service's operation for three years while awaiting national legislation.

The constitutional legitimacy of the regional initiative was confirmed on 13 December 2021, when the Constitutional Court, through ruling No. 241, rejected the appeal brought by the Presidency of the Council of Ministers against Campania's law. This historic decision not only safeguarded the regional model but also accelerated political momentum at national level, prompting multiple parliamentary groups to submit bills that were later examined by the Social Affairs Committee and eventually merged into a unified proposal.

Today, more than 148 psychologists operate within Campania's Primary Health Districts. In the first year of implementation, they conducted 67.961 consultations and took responsibility for 13.895 patients. These data underscore the strong demand for accessible, early, and community-based psychological support, and highlight the effectiveness of a structured, interdisciplinary first-level service endowed with its own organizational and functional autonomy. The Campania experience thus provides a concrete demonstration that a preventive, proximity-based model of psychological care is not only feasible but essential for meeting population needs.

Discussion

Since the pioneering reforms of the 1970s, Italy has been internationally recognized for its humanistic approach to psychiatry and for the integration of community care (Tansella & Thornicroft, 2009). Yet the system has often struggled to consolidate this heritage within coherent national frameworks.

The recent experience of Campania, where primary care psychology has been implemented at scale, illustrates that transformative models are possible when governance structures explicitly recognize the preventive and community-based functions of psychological care. This regional case demonstrates that when psychologists are embedded within primary care settings, access improves, stigma decreases, and early intervention becomes a realistic goal rather than an aspirational principle.

The PANSM 2025-2030, while inspired by progressive principles, risks perpetuating a duality: a rhetoric of innovation coexisting with an administrative apparatus still rooted in hospital-centred governance. From a professional psychology standpoint, this duality has profound implications. The psychologist remains largely confined to secondary and tertiary care, where intervention is often limited to severe pathology. This not only restricts professional expression but also prevents the system from benefiting from psychology's full preventive and developmental potential (Salvatore & Cordella, 2023). The emergence of the psychologist of primary care in certain regions demonstrates that alternative models are both viable and effective. By

embedding psychological expertise within community settings, these initiatives have improved early access, reduced stigma, and fostered empowerment (AltraPsicologia, 2024). However, the absence of national recognition and structural support risks leaving these experiences isolated. At stake, therefore, is not simply a matter of professional representation but the very nature of public mental health in Italy. A system that continues to equate mental health with psychiatric illness cannot fully respond to the complexity of human distress. To fulfill its promise, the PANSM must evolve from a model of treatment to one of promotion, from care of illness to cultivation of well-being. As the Campania experience suggests, this transformation requires recognizing psychology as a cornerstone of primary and community care, not as an accessory to secondary services.

This transformation requires the presence of psychology not at the margins but at the centre of planning, implementation, and evaluation (WHO, 2021).

The challenge is to transform the Plan's vision into a coherent and participatory strategy. This implies rebalancing governance structures, strengthening psychological and community-based services, and establishing clear mechanisms of accountability. The creation of stable inter-professional networks between psychologists, general practitioners, educators, and social workers is crucial. Furthermore, the monitoring of the Plan's outcomes should not be an internal bureaucratic exercise but an open, participatory process involving professional associations, universities, and users (WHO, 2022). Equally vital is a renewed investment in training and research. Universities and postgraduate institutions must prepare future professionals to work within integrated systems, capable of navigating both clinical and social dimensions of mental health (Salvatore & Cordella, 2023). Collaboration with regional health authorities can ensure that evidence-based innovations are shared and adapted across territories, reducing inequalities in access and quality.

Finally, the Plan should explicitly recognize that mental health is a field where cultural values, social justice, and professional ethics converge. A biopsychosocial perspective is not only a methodological stance but also a political choice: it affirms the right of individuals to receive care that acknowledges their subjective experience and their participation in the community. Psychology is indispensable for realizing this vision (WHO, 2021).

Conclusion

The PANSM 2025-2030 articulates a vision aligned with contemporary global paradigms of prevention, integration, and person-centred care, yet it remains constrained by institutional inertia and the predominance of medical frameworks. Bridging this gap demands a cultural and organizational shift that restores psychology to its rightful place as a central component of mental health policy. If the Plan succeeds in embracing this shift, empowering primary care psychology, fostering community engagement, and valuing interdisciplinary collaboration, it could become a genuine catalyst for innovation. Otherwise, it risks reinforcing the very limitations it seeks to overcome. The future of Italian mental health care will depend on the capacity to transform this Plan from a document of intentions into a living system of practices that are scientifically grounded and socially equitable.

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