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DEPATHOLOGIZING AND EMANCIPATING CLINICAL PSYCHOLOGY IN THE CONTROVERSY OVER EDUCATIONAL ITINERARIES

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This article proposes a critical analysis of the anatomical-clinical and psychopathological model, claiming epistemological, methodological and technological independence in psychology and professional training for analysis and solution of psychological problems. This perspective should be kept in mind in the current debate on plans of study in Clinical Psychology in and out of the scope of healthcare. A study plan is proposed for a Master's degree in Clinical Psychology for professional practice outside of the health-care system, and opportunities and risks of the study plans for Internal Resident Psychologist (IRP) and General Health Psychologist (GHP) are also discussed.
Key words: *Psychopathological model, Epistemology, Clinical Psychology, Psychology education, Intern resident psychologist, General health psychologist.*

En el presente artículo, se propone un análisis crítico del modelo anatomoclínico y psicopatológico, se reivindica la autonomía epistemológica, metodológica y tecnológica de la Psicología y de su capacitación profesional para el análisis y solución de los problemas psicológicos. Esta perspectiva debería ser tenida en cuenta en el debate actual sobre los itinerarios formativos de la Psicología Clínica dentro y fuera del ámbito sanitario. Se plantea un itinerario formativo de Master en Psicología Clínica para el ejercicio profesional fuera del sistema sanitario, se plantean las oportunidades y riesgos de los itinerarios formativos del Psicólogo Interno Residente (PIR) y del Psicólogo General Sanitario (PSG).
Palabras clave: *Modelo psicopatológico, Epistemología, Psicología clínica, Formación del psicólogo, Psicólogo interno residente, Psicólogo general sanitario.*

The article presented here joins the debate on professional plans of study in clinical psychology with a critical analysis of psychopathological orthodoxy, from a perspective of independence and emancipation of psychology compared to the anatomical-clinical and psychopathological model, analyzing the dilemmas posed by current plans of study.

INDEPENDENCE AND EMANCIPATION OF CLINICAL PSYCHOLOGY

A critical analysis of psychopathological orthodoxy

In a previous article in *Papeles del Psicologo* (López and Costa, 2012), we again argued for an epistemological and ethical rebellion, involving a critical analysis of psychopathological orthodoxy, because of its radical *epistemological insufficiency* in explaining psychological problems, and a radical change in the paradigm that underscores the *epistemological, methodological and technological sufficiency* of psychology paradigms for in-depth understanding of the sense of psychological problems, and the suffering those problems often cause. In this article, we wish to share some reflections on how this critical analysis and paradigm shift, which we would like to continue to delve into (Cósta and Lopez, ms. in preparation) merge to provide the basis for a process of *independence and emancipation* of psychology from the anatomical-clinical and psychopathological model.

A lively, open debate

We are doing this at what we believe to be a crossroads in the future of our profession. It is a time of enormous strengths from the social prestige acquired by psychology as a discipline with consolidated paradigms that provide effective response to psychological problems, as rightly pointed out by Rodríguez Sutil (2013). This is not simply a matter of defining what a psychological problem is or a making a decision about who should define how a vital experience can become a problem. But it is also a time of risk in which a lively, open debate is arising, with important disagreements and positions concerning the academic configuration and professional practice of clinical psychology, considering the current title of

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Psychologist Specialist in Clinical Psychology (PSCP) created by Royal Decree 2490/1998 and the recent creation of the Master's Degree in General Health Psychology (MGHP) by Law 33/2011 on general public health. Different epistemological, academic, legal, and professional perspectives appear in this discussion, and this enriches it. We think this transcendental debate, which respects the various perspectives, may be very fruitful and has a strategic projection. We would like to join this discussion from a perspective based precisely on the independence and emancipation of the epistemological, methodological and technological discourse of psychology. It is an open, arguable perspective in a context in which dialogue and deliberation are essential, and we do not wish to be absent from it.

The attributes of an independent, emancipated discipline

The independence and emancipation we refer to have their own attributes. Psychology, in its historical evolution as a scientific-technical discipline, has reached an epistemological *independence and sufficiency* given it by its own discourse, analysis levels and profile, which differentiate it from other bordering disciplines. It has its own independent methodology and technology for the interpretation and understanding of human behavior, and for the analysis, explanation and solution of psychological problems, wherever they occur, in work, education, family, health-care system services, open community or in the intimacy of the bedroom. Its methodological and technological tools do not have to be provided by either the anatomical-clinical model, or the health system institutions in which this model is hegemonic, because psychological problems are not a matter of clinical anatomy, or mental pathologies, or symptoms of mental pathologies. As a professional practice, and in particular, as a profession competent in the analysis and solution of psychological problems, whether we call it clinical psychology, psychological counseling or anything else, it is *professionally independent*, like any other profession in society, and it does not need permission, or if applicable, veto, from any other profession for its practice. Academic institutions must continue guaranteeing this independence, then, as they have done to date, in their rigorous training for specialized professional practice in the analysis and solution of psychological problems.

Other voices demanding critical analysis, independence and emancipation

Other voices have recently joined in this critical analysis and paradigm shift. Issue 61, April-June 2013, of *Infocop* echoes three decisions that affect the *DSM* classification system and coincide with the recent publication of *DM-5: The U.S. National Institute of Mental Health (NIMH) dropped the DSM classification, the British Association of Psychology (BAP) called for a paradigm shift in mental health, and a group of British psychiatrists requested elimination of the DSM and the ICD*. In fact, these three decisions were for different reasons.

Last May 13, 2013, the Clinical Psychology Division (CPD) of the BAP, apart from pointing out some advantages of the DSM and ICD, also criticized the conceptual and empirical limitations of these classification systems and proposed a paradigm shift to a conceptual system based on psychological formulation of problems and not on the disease model. "*The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a 'disease' model.*" This is also our call and we celebrate the clarity with which it is suggested. This group of British psychiatrists proposes abolition of the DSM and the ICD, and an alternative paradigm based on evidence that is useful to clinical practice.

Lilienfeld (2012) states the need for professional psychology organizations to make a public declaration on the distinction between psychology and other related professions, psychiatry in particular, and the sufficiency of epistemological and methodological postulates of psychology for the evaluation and solution of psychological problems.

The decision by the NIMH also considers the DSM insufficient, but goes still further in its reaffirmation of the anatomical-clinical and psychopathological model ("mental disorders are biological disorders involving brain circuits"), because, according to the NIMH, "Patients with mental disorders deserve better... by developing a more precise medicine." We also believe that it is necessary to go beyond it, however, not in the direction marked by the NIMH, but in the direction of a depathologizing critique of superficial words in mental

illness and rhetoric of symptoms. It is in this critique and in the models that psychology proposes where we can find the paradigm shift proposed by the DCP and the alternative paradigm demanded by the group of British psychiatrists, and not in a supposed imbalance of neurotransmitters in brain circuits, the modern paradigm of a Hippocratic/Galenic imbalance in the humors, where the precision and care required by persons who experience psychological problems, called "*patients with mental disorders*" by the NIMH, are to be found.

THE SEVEN METAMORPHOSES

Half joking, in a recent meeting of the Spanish Society for the Advancement of Clinical and Health Psychology (SEPCyS) held at the offices of the Official Association of Psychologists in Madrid, we posed a critical analysis of the psychopathological model using the metaphor of the *path of the seven metamorphoses*. This metaphor served precisely as a critique of the psychopathological model and to show the sufficiency of psychology's epistemological, methodological and technological sufficiency, arguing for its independence and emancipation, and join, from our perspective, the lively, open debate mentioned above.

In applying anatomical-clinical physiopathological and etiopathogenic models to psychological problems, a *category error* was made: inserting a phenomenon, the transactional vital experience of a psychological problem, in a category which does not correspond to it, the category of diseases, of pathologies, of psychopathologies, as formalized by Kurt Schneider. In the words of Thomas Szasz, it was "*the worst error of logic in modern psychiatry*." When the anatomical-clinical model is confronted with any human experience, for instance Watson and Rayner's well-known Little Albert experiment, in which a child's phobia of a white rat and other white objects went through seven metamorphoses that denaturalized any sense of psychological problems.

The first metamorphosis was *naming* a vital experience. Experts consulted said that this vital experience of fear, avoidance and anxiety was called a *phobia*. The second consisted of objectifying the name: the name was a thing, an entity really existing, different from the lived experience. They said, "This child has a phobia." The third is a metamorphosis of *cerebral location*: what was a vital experience *between* the child and the animal, which he played with before and now fled from, became a phenomenon that occurred *in* the child, *inside* him. From being a *transactional* event it became an endogenous phenomenon with its center and its cause in trouble with neurotransmitters going from one place to another along neural circuits in his brain, according to neuromythological fantasies ("*the brain constructs a mind*," as Antonio Damasio says). Some, to give their discovery more emphasis, even pointed their finger at their head saying, "*It's all here, it's something mental*," trying to show that the mind was something that was inside the head, and more specifically, in the brain.

The fourth is a metamorphosis of *pathological declaration*. They said, "*What the child has inside is a mental pathology that he is suffering from.*" But, since no more evidence for the supposed pathology was provided than the vital experience they had started out from, and the mere fact that someone declared that someone else was suffering from it ("*It is a pathology because I say so, even though I cannot demonstrate it,*") it was a merely declarative pathology, a statement empty of referral content, a pathology invented verbally, a "*profession of faith*" (K. Schneider), mere rhetoric, in conclusion, just words with no basis. The fifth is a *tautology*. When experts were asked, "*how do you know that he is suffering from a mental pathology?*" they answered, "*very simple, because he flees, avoids and feels fear and anxiety,*" believing that they were thereby equipping their invention with evidence and power of proof, although it was no more than a tautology.

The sixth metamorphosis is *taxonomic*: the mental pathology which the child suffered from belonged to a group of special pathologies called *anxiety disorders*, thus overlooking all the other components of the experience that had caused even the anxiety itself, and as if that group of pathologies were also a phenomenon that really existed in the mind and not an invention. The seventh is *etiological*. When the experts were asked why this child experienced avoidance, fear and anxiety, overlooking the conditional and operant transactional experiences that determined the problem, they committed a severe *logical and epistemological error* by saying that the *cause* of the child's problem was the phobia that he was suffering from and that his fear and his avoidance were the *symptoms* of that psychopathology. The thing that was inside the child's head and which was a mental pathology now appeared, as if by magic, as the cause of what was happening to the child.

The path covered by the anatomical-clinical and psychopathological model through seven metamorphoses, and the enormous facility for making this kind of rhetorical and declarative metamorphosis, led to a *pathological colonization of life*, of vital experiences and of problems of life. Any rare, problematic, incomprehensible behavior, not just a phobia, but also depression, sexual problems, voices that someone says he hears, self-mutilation or delusions, could come under suspicion and are all candidates for entering the psychopathological kingdom. This further produced, in the words of Szasz, a "*chaos in psychiatric nosology*" (Szasz), which in our opinion, the DSM-5 has secured.

TWO DIFFERENT INDEPENDENT UNIVERSES

The seven metamorphoses that define the anatomical-clinical and psychopathological model confront *two different universes*: the universe of epistemology, methodology and technology typical of that hegemonic health-care system model and professional sphere of medicine and psychiatry, and the epistemology, methodology and technology typical of the models of psychology that extend their competence beyond the limits of the health-care system, even though, as shown below, they still have a wide field of intervention within it. Although there are a multitude of intersections between these two universes, we think it is important from the viewpoint of independence and emancipation, *to clearly show their boundaries as well.*

Neither mental pathologies, nor psychopathologies, nor symptoms of pathologies

The models psychology uses to analyze, explain and understand psychological problems are epistemologically radically different from the anatomical-clinical model, which, of course, is legitimated in its study and treatment of human illness, but which constitutes, as mentioned above, a category error when applied to psychological problems, which are not diseases.

In the psychopathological model, experiencing fear, avoidance and fleeing is a *mental symptom* of a *mental pathology* located in and caused by the brain. For psychological paradigms, that experience is the result of conditional, operant biography-context transactions which are the constitutive cause of the experience. Hyperalertness, fear, fleeing and avoidance are not symptoms of a pathological cause, but concomitant components of the experience. There is no pathology or psychopathology here, there is acquisition and development of an experience that may or may not become a problem for the person who lives it. In the first, it is the relationship between the mental symptom and the supposedly pathological location and cause that is sought, and supposed neurological markers are identified as the supposed center of the pathology. In psychology, functional relationships that determine and explain the experience and identify the biographic and contextual variables that intervene in those relationships are sought. In the other model, the significance of the experience is defined by the nature of the symptom of the supposedly underlying pathology. In psychology, the significance of the experience is defined by the complex biographic functions that such hyperalertness, fleeing, avoidance and fear comply with, and by the other biographic and contextual components of the experience. For the anatomical-clinical and psychopathological model, this and many other experiences are often "psychologically incomprehensible" (Vallejo-Náguera), or an "anthropological mystery" (K. Schneider), because they are unable to accurately identify the supposedly pathological cause the symptoms derive from. In psychology models, the psychological problems are by definition "comprehensible," which does not lessen the human depth of their significance, or often, their suffering. In the first, the psychological experience is artificially fractioned and one of its components, anxiety, is removed to later constitute it as the main mental symptom, and thereby define, by obviating fleeing and avoidance, the nature of the entire experience as, "anxiety disorder". In psychology, the experience is an integral biographic experience with biographic and contextual components of which anxiety is only one, and in which fleeing and avoidance are functional determinants of the acquisition and maintenance of the experience in the biographic history.

The universe of psychology and the universe of the health-care system

Emancipation from the anatomical-clinical model and its derivative, the psychopathological model, also implies, in our opinion, that the epistemological, methodological and technological universe of psychology and the psychology that undertakes analysis and understanding of psychological problems, *not be defined per se* from the logic of languages, institutions and professionals in the

health-care system universe in which that model has a hegemony. The boundary that delimits the universe of psychology is not identical to the boundary that delimits the scenarios of the health-care system, nor do its methods and techniques for intervention in psychological problems have those scenarios as their exclusive field of deployment, nor are hospital rooms or health-center doctors' offices its training and learning workshops by definition, although they may also be deployed and trained in them.

Royal Decree 2490/1998 frames the PSCP degree in the area of education of *health-care specialists* trained for performing *health*-care activities in the *health-care* system. In coherence with this, Sanchez, Prado and Aldaz (2013) refer to the psychology practiced in the health-care system as *health psychology*, and consider that in this case, psychology and psychology professionals should adhere to the logic and rules of that system. Also out of coherence, we believe they do not have to do so when they practice their functions of intervention in psychological problems *outside the limits of the health-care system*. Analogously, they would then be practicing *non-health-care clinical psychology*, which as we describe below, has already had a long life.

Openly recognizing the status of psychology within the health-care system and delving deeper and deeper into it, either through the development of PSCPs in the scope of health-care or through the outcome of the Master in GHP, it is a splendid sample of the expansion of its potentials and its independence is completely compatible with the shared knowledge and interdisciplinary professional practice taking place in the health-care system. But this expansion should not take place by lessening the status and potential it already had and has been offering outside of the health-care system. What psychology and the psychological profession are building and are going to continue building up in the health-care system is a strength that should not be acquired at the cost of weakening other already consolidated strengths. Their affirmation and self-affirmation do not have to be built on the negation or annulment of their independence. It is the epistemological, methodological and technological power that psychology shares with the health-care system, and which is enlarged, not lessened, by being shared. We therefore believe that it is a mistake to assume that psychology or clinical psychology is by definition and *per se, health-care psychology* and the professional health-care practice.

AN INDEPENDENT, EMANCIPATED CLINICAL PSYCHOLOGY

Competent, independent clinical psychologists

Throughout our recent history, by which we mean even back to the seventies, completely independent professionals have been analyzing, understanding and trying to help solve psychological problems in different social and institutional spheres, including, of course, the health-care system, but also outside of its boundaries, and in fact we dare say, even mostly outside of this system. They thought and continue to think, as we are reminded by the National Association of Clinical and Health Psychologists (ANPCS) in a recent communication, that they were and still are *clinical psychology professionals*, if we consider that this practice, beyond controversial verbal equivalences of the word "clinical", is a practice that deals with those problems wherever they arise.

In fact, for many years, many of these professionals, having concluded their studies in psychology, were hired by City Councils and Regional governments as psychologists, and have practiced their clinical functions as completely independent professionals who are professionally, legally and in salary, the equals of other professionals. Even in the education system, in addition to their psycho-pedagogical practice, many of these psychologists performed and continue performing clinical functions as completely independent professionals, without legal restrictions and without explicit or implicit references to the health-care system, although within the demands of professional and ethical rigor.

The psychologist's practice and the profession's social prestige

During this time, many psychologists have been making competent clinical interventions backed by educational institutions, professional organizations and society, without understanding at any time that they were practicing a health profession and without being considered health establishments, or therefore, having to give explanations to health authorities or receive any accreditation from them. We think this professional practice has been one of the factors determining the social prestige of the profession, long before the creation of the PSCP degree.

The public, families and couples, have gone to them knowing they were not health-care establishments, but a perfectly qualified professional establishment in which their problems and suffering could be discussed,

understood and solved cooperatively, without being held as "mental pathologies" or "biochemical imbalances" of their brain. Many people today would stop going to these practices if it was implied that they were suffering from some "mental pathology", or if it implied that their problem was being treated as if it were pharyngitis. We fear, however, as also argued by Echeburua et al. (2012), that the growing pathologizing colonization of life's problems, promoted by the instances that have a hegemony in the psychopathological model, could be inoculating people and society with the belief that almost any problem in life can be a biochemical cerebral pathology that should be taken care of in health-care establishments and by health-care professionals. Furthermore, such pathologization goes hand in hand with "healthization" and "health-carization" of life.

More and better clinical psychology

In the nineteen-seventies, professional responsibility and a desire to offer society an ever-more qualified service led to numerous private and official educational initiatives to guarantee that clinical psychologists are increasingly competent.

Prestigious psychology centers set up training programs that continue to be given. Several universities have created Clinical Psychology Master's programs in recent years, some of which we have had the honor to participate in as professors, and which are provided with due solvency and scientific-technical evidence as also noted by Carrobles (2012). We have no doubt at all that these programs have had and are still having a cardinal role in strengthening the *specialized professional competence of clinical psychologists for intervening in the analysis and solution of psychological problems,* and in shoring up the independence and emancipation of psychology as a discipline and as a professional practice.

PROPOSALS FOR CONTINUING DISCUSSION

It is not our intention to simplify the complicated matter in the lively, open debate to which we refer or undertake now all its components, nor would we be able to do so. We limit ourselves to offering, in the form of proposals, a perspective for continued discussion.

Proposal 1. Guarantee the independence and epistemological, methodological and technological emancipation of psychology

The first proposal invites deliberation considering a critique of the anatomical-clinical and psychopathological model, a critical analysis of the taxonomies and terminologies that camouflage this model, and the epistemological, methodological and technological independence of psychology as a scientific-technical discipline and as a competent professional practice in the analysis and solution of psychological problems. This seems to us to be an unavoidable reference for it to go forward with its *own discourse* and continue advancing. The proposal has to have, in our opinion, important implications for the definition of the curricular content of any study plan for a Degree in Psychology, and PSCP or MGHP degrees, in which the anatomical-clinical and psychopathological model, with its rhetoric about the origin and cause of illness, its rhetoric about symptoms and their taxonomies, even when there has to be a dialogue in interdisciplinary work (see López and Costa, 2012 a and b), does not conform to the epistemological and methodological demands of psychology. We agree with Rodríguez Sutil (2013) that an interpretation of the problems, which we can then continue discussing, is indispensable, whether called psychodiagnostics, psychological evaluation or functional analysis of behavior, but it must not be an anatomical-clinical and psychopathological interpretation.

Proposal 2. Specialized academic training

The second proposal refers to the *specialized academic training* which to date the university and other accredited institutions have been offering psychology professionals. We are aware that this proposal clearly contrasts with the two health degrees subject of the debate we are alluding to. In any case, we believe our suggestion has to be present in the discussion and that it has to be specified in the corresponding plan of studies.

The principles of specialized training

This specialized training for intervening in the analysis and solution of psychological problems emanates, consubstantially and logically, from the assumptions that provide psychology with its emancipation and independence, as well as its historical practice. Such training pertains to psychology in its own right and is not given it, although it seems obvious to say so, by assumptions of the anatomical-clinical model, nor is it invested with that prerogative by its insertion in the health-care system, nor does it have to request accreditation or

permission from this system for its practice, nor does it have to be acquired, as a professional praxis, necessarily in hospital wards, or in any of the establishments of the health-care system. Psychology does not need to enter the health system to become recognized as a doctrinal and technological corpus. Its recognition was achieved on its own, prior to entering, inside and outside the health-care system. What would obviously be nonsense, would be our inadvertently, once having entered the health-care system, allowing its independent recognition to be held prisoner and not permitted by this system to be shown in many other broad territories where it has always been practiced, which could be defined properly as, "undue appropriation." This is something that has not even happened in biology, physiology or biochemistry, which, once they had entered in the health-care system and become fully integrated, did not lose, however, their scientific-technical independence outside of the health-care system.

But it is not enough to theoretically recognize this independence. It must be taken to its furthest consequences as a matter of principle. This means that educational institutions and professional organizations have to continue recognizing *postgraduate specialized training* for the analysis and solution of those problems through the corresponding *postgraduate university degrees*, and continue guaranteeing other professionals that, after the corresponding bachelor's degree, they have access to it and practice it with full guarantees in any area of society, and of course, *outside the health-care system*.

If we do not do that, if we accept as a consummate fact that the health-care system is the one that attributes exclusive definition of what psychology is or is not permitted to do as a scientific-technical corpus, if the profession respects this appropriation and accepts relinquishing its professional independence outside of the limits of the health-care system, what could happen, as in fact already is occurring, is that professional practices begin to proliferate, some pseudopsychological, that skillfully avoid "health-care" connotations to be able to elude legal and professional restrictions that the health-care system has already made on the professional practice of psychology in wide fields of intervention. With it, the profession would be losing the opportunity, and the responsibility, of defining the ethical and professional criteria that must govern quality services to society.

We do not treat mental pathologies or patients with mental pathologies

Alluding to a study by Santolaya, Berdullas and Fernández Hermida (2002), in which 70% of the psychologists surveyed considered themselves clinical psychologists, Zych, Buela-Casal, Bermúdez and Sierra (2012) lament that, in spite of everything, only a few psychologists in Spain have the possibility of being recognized as health-care professionals, although they say that, "*of course, it is understood that non-health-care professionals cannot treat patients and are not integrated in the health system.*" We do not want to misunderstand this statement, but it could mean, as a syllogism, that if you are a non-health-care professional and not a part of the health-care system, you cannot treat patients. Therefore you are a non-health-care professional and are not a part of the health-care system, and ergo, you cannot treat patients. We could stand on our scholarly heads and say, "I concede to the majority, the minority and the conclusion," treating patients and pathologies. But the depathologization and epistemological, methodological and technological independence we are pushing for saves us the scholastics. In fact, clinical psychology *does not treat pathologies or patients*, because psychological problems are not diseases, are not pathologies, or psychopathologies.

From this perspective, we could formulate another syllogism. If you are a psychology professional competent in the analysis and solution of psychological problems, and not necessarily a health-care professional, you can intervene in solving those problems, and not necessarily within the health-care system. Thus you are a psychology professional with proficiency legitimately acquired in academic institutions with an official postgraduate degree ergo you legitimately intervene in the solution of those problems.

To ensure the educational plan of studies of the psychologist specialist in the analysis and solution of psychological problems

This postgraduate training would be given by means of degree programs such as *Psychologist specialist in analysis and solution of psychological problems* (PEASP), *Psychologist specialist in psychological counseling*, or others that could be defended, but always in the understanding that the degree would give the necessary and sufficient accreditation for professional practice outside of the health-care system as, we insist, it has been doing up to now, and whose contents would have to be

equivalent to already existing degrees in clinical psychology which do not follow the plans of study of the PIR. The denomination *Psychologist specialist in non-health-care clinical psychology* might also be proposed, assuming that the degree created by RD 2490/1998 refers to *Psychologist specialist in health-care clinical psychology*. As long as the training ensures the education we are demanding, even the name "specialist" could be obviated and refer only to the *Master's degree in analysis and solution of psychological problems,* or *Expert in analysis and solution of problems,* or *Master in psychological counseling*. In their professional practice, psychologists could be defined as *Psychological Counselor, Psychological Consultant,* titles society would gradually incorporate as definitions that correspond to expert professionals in the analysis and solution of psychological problems.

These and other titles would avoid conflict with the PEPC degree. In any case, and in strict epistemological and terminological rigor, the conflict would not even exist if we consider the subject of the education we are pushing for "psychological problems", and not "mental pathologies, which, according to RD 2490/1998, would be the subject of the PEPC. We (López and Costa, 2012a) think *Psychological Counselor* could be considered precisely a *genuinely depathologized clinical psychology*.

Concerning *plans of study*, during the 3rd and 4th years of the undergraduate coursework, students who are planning on a profession in clinical psychology outside of the health-care system could choose *optional courses related* to this area of intervention. At the end of the four undergraduate years, they would have access to the *corresponding two-year postgraduate Master's degree* which would accredit them for professional practice in coherence with the European Higher Education Area (see Carrobles, 2012).

Legislative and curricular development of this Proposal 2 would require universities and the Organization of Official Psychology Associations to prepare the corresponding proposal for official coursework in the Master's degree to the General Council of Universities. The degree would have to accredit having passed the corresponding ECTS credits in both the BA degree and Master's and provide a guarantee based on evidence that the specific knowledge and proficiency necessary for the analysis and solution of psychological problems in conformance with the epistemological, methodological and technological principles of psychology has been acquired.

Proposal 3. Not only, but also, in the health-care system

Proposals 1 and 2 establish an independent field of knowledge and action, not subsidiary to others, but not a field closed in itself either. On the contrary, it is completely open and willing to spread its competences in all of those areas and sectors of society where human beings live and behave and where they experience vital problems and may be hurt and suffering from them.

How not to recognize that many behaviors and life styles, avatars of life and psychological problems have a strong *impact on health-illness phenomena*, that many health-illness phenomena, like the integral biographic experiences they are, have numerous psychological components that psychology is competent for understanding and explaining, and that many of those phenomena, although not all nor always, are cared for in the primary and hospital health-care system.

In many of these phenomena, psychology is also competent to intervene, and also precisely in the health services system, both in preventive and health promotion intervention, and in its treatment. Our own personal professional experience and that of so many colleagues is a faithful testimony. In these cases, psychology is *also a health-care profession* in full right. Echeburúa, Salaberría, de Corral and Cruz-Sáez (2012) and Carrobles (2012) make an authorized reference to the large specialized field of *Health Psychology*.

Proposition 4. Opportunities and risks of the Clinical Psychology Specialization, by the PIR

One of the most highlighted examples of the entry of psychology, and in particular of clinical psychology, in the health-care system has doubtless been the creation of the PEPC degree by Royal Decree 2490/1998.

We cannot but openly express the highest acknowledgment for the arduous and complicated efforts made by many psychology associations and by official and academic organizations in achieving this desired goal. With this specialization, an inroad would be opened for the profession in the health-care system, not too wide because of what we now know, but an inroad nonetheless. It would mean the entry of psychology in the health-care system under equality of conditions with other professions in the health sector and psychologists' ability to make psychological evaluations and treatments is recognized.

In this open debate, various perspectives are being made explicit that show the strong points as well as the weakness of the specialization. Sánchez, Prado and Aldaz (2013) describe what this specialization and its consolidation, as legitimately claimed, has meant and means, given its adequate legislative support and accumulated experience. Although it is true that the contents of the educational program for the Clinical Psychology specialization established by Order SAS/1620/2009 of June 2nd seems to us to be so wide that it is hard to consider it a specialization, and seems more generalist, or rather, as a general set of all the possible specializations of psychology. To this extent, such a wide profile could, in the mid-term, impede configuration of other more specialized study plans depending on social needs and demands.

In any case, it would be naïve to ignore the risks intertwined with opportunities and the price that had to be paid. From that moment, specialized training for analysis and solution of psychological problems would have to be acquired, not *in addition to or also, but if and only if* they are acquired within the health system, most probably in the anatomical-clinical and psychopathological model, and often under the tutelage of the units directed by psychiatry professionals who consider this model something that belongs to them by right. It was assumed, and almost generally accepted, that any psychological intervention on psychological problems was an intervention by the health-care system, and that anything that was not in that category was not possible, when in fact it had been. The doctrine and technical body of psychology, which was generously offered to share power with the health-care system, was soon included and defined exclusively by the narrow limits of this system.

But moreover, Article 1 of Royal Decree 2490/1998 states that the degree will be necessary to be able to expressly use the title of Psychologist Specialist in Clinical Psychology and to hold employment in public or private establishments or institutions. Thus psychology professionals who up to then were, to the letter of the law, competent to intervene in psychological problems, even when they were not adorned by the qualification of "specialist", suddenly lost their attributes, and the specialized competence they had trusted the Official Association to have sufficiently invested in them after their five years of basic education, and two or more years of specialization in clinical psychology. This, in our opinion, was a setback for the history of the profession that we would hope the debate in which we are immersed would contribute to repairing.

As clinical psychology is defined exclusively and per se as a *health-care activity,* establishments where clinical psychologists practice have to be *health-care centers* that would have to be regulated in conformance with Royal Decree 1277/2003, which establishes the basis for authorization of these centers. Psychology centers that had had a key role in the social prestige of psychology and providing quality services to the public, and which at no time had been considered health-care services, no longer had the independence they had enjoyed and were defined as health-care establishments.

One of the important rules of the game of system it was entering, and which really openly conflicts with our critical analysis of psychopathological orthodoxy, is that the purpose of the care of those specialized psychologists was *mental pathologies* (Third additional provision of RD 2490/1998). This definition, which is coherent with the anatomical-clinical model that understands pathologies, and which is hegemonic in the health-care system and among the majority of its professionals, could absorb the explanatory and interpretive models derived from psychological paradigms.

Proposal 5. Opportunities and risks of the Master's degree in General Health Psychology

A good part of this debate lies in the controversies that arise from the respective competencies of PSCP and GHP in the health-care area.

We believe it makes sense for the Law on Public Health to insert psychology in the scope of Public Health and community health and its actions, among which are health surveillance and promotion, prevention of health problems and the determinants in reducing their incidence and prevalence, protection of the health of the population with regard to the natural and socially-constructed environment (home, work, school, places of leisure, urban spaces, lifestyles), evaluation of impact on other health policies, and proper coordination between the health sector and others, since they are areas in which psychology is competent to make significant scientific-technical contributions.

GHP as a health-care profession

This law stipulates that graduates in psychology shall be considered health-care professionals with the title of GHP when they carry out their professional activity on

their own or for others in the health-care sector, as long as they have the official Master's degree in GHP. The study plans corresponding to this degree shall guarantee acquisition of knowledge and proficiency necessary for performing the activities of the GHP health-care profession. Universities that teach the Master's programs shall regulate the procedure for recognition of European credits for said Master's degree for graduates in psychology before this law goes into effect, evaluating the extent of equivalence accredited by professional experience and training acquired by the party interested in Health Psychology. They shall also design the undergraduate degree in psychology, including at least a plan linked to Health Psychology. We think that these references in the Law on Health Psychology are significant to the extent that they establish equivalences between it and GHP.

Health-care profession, but outside of the National Health System

Notwithstanding the above, the law stipulates that psychologists who carry out their activity at centers, establishments and services of the National Health System (NHS) or chartered for services derived from the portfolio of common services that correspond to them, must be in possession of the PSCP degree. It may be derived from this that the law which defines the GHP as a health-care profession nevertheless vetoes professional practice in the NHS, which has important and serious consequences for design of the study plans for psychology in the health-care sphere and for the professional practice of psychology.

In the panorama of scarce employment opportunities for the profession, it had been desired for the MGHP to be seen as an opportunity that responded to the precarious professional and employment situation derived from the shortage of openings for PIR positions and the demand for greater presence of the profession in the health-care system. We think it is necessary, having learned from the experience with the PSCP, to be aware of the nature of this opportunity, and of its risks, just in case it does not crown our dreams and is, on the contrary, the source of new disappointments.

If the proposal for the law is read carefully, and the functions assigned to the GHP and the improbable short-term professional options in terms of real employment positions are analyzed, it might be just another lure. There is no time horizon in view for the definition of the characteristics of employment positions or for the opening of such positions in the health system for professionals with this degree. What are the GHP going to do and who are they going to be hired by and where? And all of this on the horizon of a current reduction in PIR positions to be opened, with perspectives for an even greater reduction.

Training for analysis and solution of psychological problems outside of the health-care system, which we claimed in Proposal 2, has been annulled since the creation of the PSCP degree, and the MGHP degree constitutes a clear setback that visibly reduces the competences of what it is supposedly going to replace.

On the other hand, the fact that GHP activity is reduced to the private sphere poses serious problems, among others, coordination with specialists and accessibility of the service. Echeburúa et al. (2012) made a lucid effort to configure GHP functions and tasks and also realized the incongruence of the private sphere of GHP activity, incongruence which seems to us to be decisive. Prevention and health promotion activities must be performed in a public sphere because to the contrary, the problems of equality are intensified. Who can pay for preventive services directed at reducing, for example, the risk habits of smoking, alcohol, drugs or habits leading to obesity? No doubt, people with higher economic power. Apart from this, how is it going to coordinate with the professionals of Primary Health Care? And with the PSCP? What is the referral system?

Psychological intervention in behavior

In any case, and in spite of the disadvantages and risks posed by the MGHP, we think it is a good idea to point out some aspects that suggest psychological intervention in behavioral and psychological problems, which could contribute to the development of a study plan for GHP as a profession in psychology, and which furthermore, open the door to the integrated field of clinical psychology and health psychology referred to by Carrobles (2012), and its inclusion in GHP in the National Health System (NHS) as proposed by the Spanish Society for Clinical and Health Psychologists (SEPCyS) (SEPCyS, 2011), as long as it is included in the NHS and the conflict of competences with the PSCP is clarified.

Order ECD/1070/2013 of June 12th stipulates the requirements for verification of the official university GHP Master's degree which it estasblishes for the practice of the regulated GHP title and profession. As a development of certain sections of Annex I of Royal Decree 1393/2007 of October 29th, establishing the

organization of university studies, the Order stipulates knowledge and proficiencies which students must acquire to perform "*research, evaluation and psychological intervention in those aspects of behavior and activity of persons which influence the promotion and improvement of the general state of health*." Two of the proficiencies stipulated by Order ECD/1070/2013 specify this even more. Proficiency 16: "*In-depth knowledge of the different GHP evaluation and intervention models, and derived techniques and procedures for approaching the behavioral disorders and psychological factors associated with health problems*." Proficiency 18: "*Design, develop and if applicable, supervise and evaluate psychological intervention plans and programs based on psychological evaluation and the concurrent individual and social variables in each case*." On top of it all, Proficiencies 17 ("*Plan, perform, and if applicable, supervise the psychological evaluation of human behavior and psychological factors associated with health problems to establish their evaluation*") and 21 ("*Perform promotional and educational activities for individual and community psychological health*") would cover a wide field of activity in health psychology. It might be assumed that if they were properly acquired, all of these proficiencies could be legitimately deployed in professional GHP practice. In this case, what would be the boundary between "behavioral disorders" which GHP could manage and those which would have to be handled by the PSCP? Or would there be no real boundary? However, the coursework that configures Master's degree plans of study, according to Order ECD/1070/2013, does not seem to us to correspond with the proficiencies described. Nevertheless, as another example of the weak consistency we think there is in the wording of the Order and the design of the MGHP itself, when the Order refers to obligatory external practice, it means it must be done in health-care centers or services with activities called *visits, clinical histories, case and care records, diagnostic and therapeutic protocols, and clinical sessions*. Specific programs at these centers cited are *partner therapy, care of behavioral disorders of the elderly, children, and adolescents, psychological support for patients with chronic pathologies*, and so forth. Can it be understood that the MGHP students doing their residency in these scenarios can do so as a professional practice when they receive the GHP degree? It might be supposed so.

The GHP Master's degree as an intermediate step in the plan of study.

The white paper entitled, *Study Plan for Psychology in the Sphere of Health-Care* published on November 12, 2012 by the National Association of Clinical Psychologists and Residents (ANPIR), the Spanish Association of Behavioral Psychology (AEPC), the Spanish Society for Advancement of Clinical and Health Psychology (SEPCYS) and the General Council of Official Associations of Psychologists is a laudable attempt to resolve what the authors of the white paper consider a "serious conflict" of proficiencies in the recently created GHP health-care profession MGHP, and the PSCP health-care profession. They believe the conflict cannot be resolved or avoided unless a BA/*graduate-MGHS-PSCP* hierarchical educational sequence is established, in which the MGHS is an intermediate step between the Clinical Psychology Specialist degree and the corresponding hierarchical professional *BA/Graduate-GHP-PSCP*.

As the authors of the white paper point out, it must be recognized as obvious that education and acquisition of proficiencies in any discipline are cumulative and sequential. But we do not think that the appearance of the MGHP justifies, even as a way to avoid the conflict, its accumulative insertion in an already established plan of studies for PSCP training with its corresponding cumulative BA/graduate-PIR educational sequence, which furthermore, by Order SAS/1620/2009, widened its contents and the duration of the plan to four years. This same Order stipulates that prerequisite studies shall be a BA in Psychology, which at the present time would be the Degree, with no suggestion of the insertion of any intermediate level. The insertion proposed would accumulate two more years, and would not in our opinion contribute any new argument of weight other than the statement itself that PSCP training has to be cumulative and sequential. Of course, it does not seem to us that this insertion, in its exaggeration, has any equivalence in the European Higher Education Area (see Carrobles, 2012). The level of prerequisite preparation in proficiencies and skills is acquired in the BA or Degree, and the level of later preparation, including aspects of health psychology, is acquired during the four years of the corresponding plan of studies in the health sphere added to the BA or Degree. Did the PIR until now not acquire the right prerequisite and postgraduate preparation and still needs a further two years of the MGHP? In other health professions alluded to by the authors, medicine for

example, after the corresponding degree, access to specializations, e.g., Family and Community Medicine, the degree held by one of the authors of this article, is through the MIR (M.D. internal residency) exam. Between the Degree and specialization there is no intermediate level. We think that the reduction in credits in the psychology study plans to which the authors allude is not something which has to be "compensated" for by the MGHP, since the education supposedly "lost" does not include curricular contents that would have to be compensated for now with that Master, and above all because the reduction in credits responds to the logic established by the European Higher Education Area, and we do not need to go into and start fixing its supposed defects now, much less with a two-year patch. In any case, just as the General Law on Public Health stipulates that the universities that train psychologists who intend to go on to the MGHP degree shall design the Degree in Psychology with at least one specific study plan in Health Psychology, in an analogous manner, the universities could design a specific plan of Degree studies for psychologists who intend to go on to the PSCP degree.

As to the rest, in view of what we have discussed above on Order ECD/1070/2013, the differentiation between at least some of the proficiencies assigned to the GHP and those of PSCP does not seem clear enough to configure the MGHP as a prerequisite to or degree lower than the PSCP. It would be desirable for the open debate to contribute to clarifying differential training between GHP and PSCP, between general psychologist and specialized psychologist, what the "complexity" of the cases determining what the two can undertake is, and what should be understood from a critical analysis of the anatomical-clinical model by "behavioral disorders" the GHP could treat and the "mental pathologies" defined as the purpose of the PSCP.

Apart from this, the MGHP is not only a study plan, independent of or combined with others, but also preparation for the *regulated practice of the degreed GHP profession*. We think that making the MGHP a study plan between other study plans contributes to ignoring the important debate on the real opportunities and risks of the GHP as a professional practice and as an employment option, if, as we have mentioned, it can really become one at some time. We would have loaded down unnecessarily a study plan without having clarified the professional and employment career of the title at the same time. If the PIR was, as we have said, an inroad for the profession, but also closed other openings for non-PIR professional practice, couldn't the MGHP itself become a road with no outlet? If this professional practice cannot be deployed in the NHS, since for this deployment the PSCP is required, it is hard to understand how the MGHP and the corresponding professional deployment can be presented as the ideal prior preparation for the PIR. If, as probably will probably happen, a large number of GHPs could not continue the plan of studies toward the PIR, given the growing limitation in positions offered, and on top of it all their professional practice in the NHS is limited and they are confronted with the gloomy panorama of professional practice as a GHP, we could find, not just thousands of graduates who could not have access to the PIR when they should have, and the thousands of clinical psychologists duly trained who cannot practice as such, but also a larger or smaller number of brand new MGHPs who would have had the glory of participating in the plan of studies for the PIR but whose plan of studies would leave them professionally out in the cold. We think that in the interest of the profession itself, it is necessary to think now so as not to be sorry later.

Proposal 6. For a strong professional alliance

Throughout the article, and with respect for other different perspectives, we have proposed our perspective and have analyzed others. This debate confronts a situation that is not easily resolved for psychology study plans or for the professional practice of psychology in the area we call clinical psychology. We are facing a problem that will be solved better to the extent that it is a challenge faced operatively and not on a field of battle among ourselves or by invalidating the different perspectives in play.

Further deliberation is necessary, although time is short and legislative and academic decisions are coming on fast. Under these circumstances, we would like to propose a meeting of all the agents involved, coordinated by the Organization of Official Associations, to table the terms of debate, the certainties, the doubts and the discrepancies face-to-face and beyond articles in journals and written declarations, to make creative proposals that make the debate an authentic win-win process.

REFERENCES

Asociación Nacional de Psicólogos Clínicos y Sanitarios (2013). Comunicado [Comuniqué].

Carrobles, J.A. (2012). Psicólogo clínico y/o Psicólogo general sanitario [Clinical psychologist and/or General Health Psychologist]. *Psicología Conductual, 20(2),* 449-470

Costa, M. and López, E. (2014). *Los problemas psicológicos no son enfermedades. Un análisis crítico radical de la ficción psicopatológica [Psychological problems are not diseases. A radical critical analysis of the psychopathological fiction].* Madrid: Pirámide (ms. in preparation).

Echeburúa, E., Salaberría, K., de Corral, P. and Cruz-Sáez, S. (2012). Funciones y ámbitos de actuación del psicólogo clínico y del psicólogo general sanitario: una primera reflexión[Functions and scopes of action of the clinical psychologist and the general health psychologist: first thoughts]. *Psicología Conductual, 20(2),* 423-435.

Lilienfeld, S.O. (2012). Public skepticism of psychology. Why many people perceive the study of human behavior as unscientific. *American Psychologist, 67(2),* 111-129.

López, E. and Costa, M. (2012a). *Manual de consejo psicológico. Una visión despatologizada de la psicología clínica [Manual of psychological counseling. A depathologized view of clinical psychology].* Madrid: Síntesis.

López, E. and Costa, M. (2012b). Desvelar el secreto de los enigmas. Despatologizar la psicología clínica [Unveiling the secret of the enigmas. Depathologizing clinical psychology]. *Papeles del Psicólogo, 33(3),* 162-171.Rodríguez Sutil, C. (2013). El fantasma del psicodiagnóstico [The psychodiagnostic phantom]. *Clínica Contemporánea, 4(1),* 29-44.

Sánchez, S., Prado, J. and Aldaz, J.A. (2013). Psicología Clínica y Psicología General Sanitaria[Clinical psychology and General Health Psychology]. Psicología Conductual, 2(1), 189-200.

Santolaya, F., Berdulla, M. and Fernández Hermida, J.R. (2002). La década 1989-1998 en la psicología española: análisis del desarrollo de la psicología profesional en España [The decade from 1989-1998 in Spanishy psychology. Analysis of the development of profesional psychology in Spain]. *Papeles del Psicólogo, 82,* 65-82.

SEPCyS (2011). *Comunicado sobre la aprobación del Título del Psicólogo General Sanitario. Varios autores. Argumentario Itinerario formativo de la psicología en el ámbito sanitario. [Comuniqué on approval of the General Health Psychology Degree. Several authors. White Paper on plans of study for psychology in the field of health-care].* Madrid, November 12, 2012.

Zych, I., Buela-Casal, G., Bermúdez, M.P. and Sierra, J.C. (2012). Is Psychology a Health Profession? An Opinion of a Sample of Psychologists Worldwide. *Universitas Psychology, 12,* 57-171.