



CHANGING IN ORDER TO PROGRESS. AN ANALYSIS OF THE DEBATE ON THE TRAINING ROUTE OF CLINICAL PSYCHOLOGY IN SPAIN

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El itinerario de formación en Psicología Clínica está siendo objeto de un gran debate en el mundo académico y profesional de la Psicología española. En este artículo se analizan críticamente los argumentos expuestos tanto por los partidarios como los detractores de que el Máster de Psicología General Sanitaria sea una condición necesaria para el acceso a la formación especializada. Se defiende claramente una secuenciación de la formación en Psicología Clínica, Grado – Máster – Especialidad, por razones lógicas, legales, profesionales, de convergencia con el modelo Europsy, y de oportunidad para establecer fuertes vínculos universidad – profesión. Se concluye que la adopción del itinerario fortalecerá no sólo a la especialidad y a la Psicología General Sanitaria, sino que puede ser una de las bases sobre las que se apoye el desarrollo científico y profesional de la Psicología Clínica en España.

Palabras clave: Psicólogo general sanitario, Psicología clínica, Itinerario formativo, Regulaciones Legal.

The training route in clinical psychology is the subject of much debate in the academic and professional world of Spanish psychology. This article critically analyzes the arguments of both the supporters and the opponents of the master's degree in general health psychology as a necessary condition for access to specialized training. A bachelor's degree - master's - specialty route for training in clinical psychology is clearly defended, for logical, legal, and professional reasons, and for convergence with the Europsy model, and the opportunity to establish strong ties between the universities and the profession. It is concluded that the adoption of the route will not only strengthen the specialty and general health psychology, but it may also be one of the foundations on which the scientific and professional development of clinical psychology in Spain rests.

Key words: Healthcare psychologist, Clinical psychology, Training route, Legal regulations.

Since the creation of the profession of general health psychologist (PGS in Spanish) in 2011, there has been a heated debate on the training process in the field of clinical psychology, stoked by academics, professionals and students, but primarily ignited by poor and chaotic regulation. The central point of the discussion is whether the new master's degree in general health psychology (MPGS in Spanish) should be an essential condition for access to the psychologist internal resident training (PIR), and thus to the title of

specialist psychologist in clinical psychology (PEPC in Spanish) or whether the current situation should continue, where this access is obtained from an ordinary bachelor's degree¹ in psychology. Thus, it is essentially an argument about whether it is worth changing or whether we should stay as we are.

It should be made clear, from these first lines, that what is being discussed is the training in clinical psychology, an area of knowledge and a profession that is not exclusive property, nor can it be reduced to any qualification. The two degrees (MPGS and PEPC) refer to the same discipline and professional field: clinical psychology, which does not exclude health psychology. It will also be accepted, to facilitate exposure, that access to the specialist training is gained with an ordinary bachelor's degree in psychology, and not, as is more correct, from an ordinary bachelor's degree in the "field of psychology". This is something that should change as soon as the administration decides to enforce the General Law of Public Health, and regulate the ordinary bachelor's degree in psychology to give access to the

Recibido: 16 enero 2017 - Aceptado: 23 febrero 2017

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¹Translator's note: There are now two different bachelor's degrees in Spain, the "Licenciatura" (an extended bachelor's degree obtained after five years of university studies) which has been replaced by the "Grado" (an ordinary bachelor's degree obtained after four years of university studies). I have translated these as "extended bachelor's degree" and "ordinary bachelor's degree" respectively in English.



MPGS. It is conceivable that, in this case, even if the ordinary bachelor's degree-MPGS-PIR route does not end up being implemented the standard access to the specialty would also change, because it would be incomprehensible for access to the MPGS to be more restrictive than access to the title of PEPC.

Recently, the Conference of Deans of Psychology of the Spanish Universities (CDPUE) seems to have made the decision to rule on whether it is in favor of the ordinary bachelor's degree-master's-PIR route or whether instead it will opt for endorsing the current situation. Perhaps the regulation of the ordinary bachelor's degree, which feels close, will stoke the debate because, as I said previously, it would be the time to change the conditions of access to the specialty. It is these conditions and the importance of the collegial opinions such as those of the CDPUE, which have prompted me to give my personal point of view on the reasons supporting the ordinary bachelor's degree-MPGS-PIR sequence and the serious disadvantages of maintaining the current situation.

THE CONTROVERSY OF THE TRAINING ROUTE. CRITICAL ANALYSIS OF THE REASONS FOR AND AGAINST

In the various articles that have dealt with the pros and cons of the training route, various arguments have been used, which I will aim to synthesize and analyze. I will group what I consider to be the main arguments into subsections to facilitate the discussion.

a) The distinction between PGS and PEPC has its counterpart in the distinction between health psychology and clinical psychology, since the legislation that establishes the PGS states that its skills have to do with the promotion and improvement of the state of health (Cortes Generales [Parliament], 2011), and in that of the PEPC it indicates that these graduates perform diagnoses, evaluations and psychological treatments of a psychological nature (Ministerio de la Presidencia [Ministry of the Presidency], 1998)

This argument has been used, both for the training route (Echeburua, Salaberría, De Corral, & Cruz-Saéz, 2012) and against it (Carrobbles, 2012; López-Méndez & Costa-Cabanillas, 2013). The latter seem to indicate that we are faced with two professionals with different backgrounds, so the PGS as a "specialist in health psychology" has a fully justified separate existence, and the former

emphasize that the PGS has a special relationship with the general concept of health, in accordance with the law that created the profession, so there should not be any competence in "mental disorders", which would be a field that belongs exclusively to the specialist. However, both arguments are extremely weak, because they ignore the basis for the creation of the profession of PGS, and also those defending one or another position contradict themselves. Thus, those who indicate the two separate paths but are against the training route, also argue that both can and must work on the same problems and have received identical training (Carrobbles, 2012, 2013, 2015), while the latter, in favor of the route, insist on the idea that this is a general psychologist, who by definition cannot have a "specialty".

I have no doubt that both professions, with a different level of qualification, have competencies in the field of clinical psychology and health psychology. The doubts about the competencies of the PGS seem to ignore the reasons for its creation. The new profession is a response to the crisis that occurred as a result of the expulsion of the non-specialist graduates in psychology from the health system by the LOPS (Generales [Parliament], 2003). At that moment, these graduates ceased to be considered a health profession and went on to have their professional continuity threatened, both those who were already practicing and those who would follow later. The strong professional protests that the LOPS triggered drove a solution, which came largely conditioned by the very reality in the mental healthcare profession. That reality is represented by thousands of psychologists, who practiced and continue to practice clinical psychology in the private sector, with a few dozen in the public sector, who were not able to obtain the specialty, suddenly finding themselves legally disqualified in an unfair way. Much of the mental health care of our country was and is covered by these professionals, something that has not changed nor does it seem likely to change in the future, due to the scarce investment in public policies of mental health (Knapp et al., 2007) –which has not increased in recent years– and the poor provision of specialist places (OMS, 2014). Added to this professional impact of the LOPS is the simultaneous disappearance of the extended bachelor's degree. The PGS was the administration's response to give back to the non-specialist psychologist, the holder of the previous extended degree, the opportunity to practice their profession and not create



administrative, legal and healthcare chaos in the area of private and public mental health. This solution must be understood within the new framework of university degrees, in which the extended bachelor's degree has given way to the ordinary bachelor's degree plus master's (Ministerio de Educación [Ministry of Education], 2015), which restores the situation prior to the LOPS. If this is the case, what logic would be behind the creating of a new profession to solve the legal problem of non-specialist psychologists and then saying that it does not qualify them to meet that need?

The broad and general competencies of the MPGS qualification enable us to state that the profession of PGS has the necessary knowledge and skills for the exercising of the profession of psychologist in the field of clinical psychology. The specialist psychologists in clinical psychology, however, can (and do) also practice their profession in the field of health psychology. Neither of the two professionals has exclusive competence in either of these areas, as stated in a recent judgment which says that "The difference between the two professions does not affect either the acquisition of knowledge or the training but rather the place where they will each be able to develop their skills and knowledge. There are only differences in the areas of professional activity" (emphasis added).

A strengthening of the perspective of health has been advocated as opposed to a "clinical" viewpoint (López-Méndez & Costa-Cabanillas, 2013). The former is seen to be closer to the epistemological and methodological assumptions of psychology, while the latter is more closely linked to a model of "disease" of a more "naturalistic" or "anatomy-clinical" origin. This debate is in full force as shown by a recent symposium held at the Autonomous University of Madrid, organized by the Spanish Academy of Psychology, which focused on the growing crisis of psychopathological diagnosis and the contributions of psychology both in the formulation of problems and the search for solutions (Fernández Ballesteros, 2017). However, this debate cuts across the two fields, clinical psychology and health psychology, and the two professions, PEPC and PGS. It is not possible to understand how adopting one position or another may be relevant in determining the links between the two professions.

A derivative of this discussion comes from the notion that the PGS, as a professional with training that is supposedly more focused on health psychology, would be better suited to meet the demand of psychologists in primary care,

where this is a reality, compared to the PEPC (Echeburua et al., 2012). This assumption is based on alleged real differences in the educational curricula and complete disregard for the current legal regulation or for the preference of the public health system to train its own professionals.

Later I will return to the subject of the training differences obtained by analyzing the contents of the respective programs, but I can say that this difference does not justify the existence of two professionals with different specialties. Moreover, the idea that the healthcare system will hire professionals trained outside of the system when it has, in this case, the PEPC, is unrealistic. But as well as being unrealistic, it would be a total and utter illegality under the current legislation. The General Law of Public Health (Cortes Generales [Parliament], 2011) vetoes the presence of the PGS within the publicly funded healthcare system to meet the demands arising from the portfolio of common services. And there is no doubt that a psychologist working in primary care has to cater almost exclusively to this type of demand (Duro Martínez, 2017).

However, I must add here that the fact that the law currently conditions the hiring of the PGS by the public health system so restrictively in the very rules that create it, seems to me to be completely unfortunate. Firstly because the practice of the profession cannot be linked to the financing of the service but rather to whether or not the individual has certain knowledge, skills or abilities. Secondly, because the PGS would be the most logical choice only where its skills and abilities are necessary, and there is no specialist who could cover that position. And, thirdly, because this limitation could hamper the very diversification of the psychological assistance within the system. It is not unusual for specialties to have been created from the needs arising in a particular field based on the work of generalists. This is how ours was born, at least.

I understand the fear of those who say that without this legal limitation, the administration could choose to cover healthcare places with less expensive professionals, since the compensation is linked to the educational level, or that taking advantage of the lower qualification other professions may try to reduce the psychologist's role to merely an auxiliary one. These ideas leave out the fact that it is the government itself who imposes the limit and if it has imposed this limit it means that it is in tune with it, since it is consistent with the overall hiring policy of the public healthcare system, of which we are one tiny part.



If at any time the administration considered otherwise, there would be nothing to prevent the rules from being changed. But this fear cannot be the reason for a qualification such as the PGS to come out with an additional limitation to its own generalist qualifications, a limitation that, moreover, has no precedent in any other healthcare qualification.

In the current situation, the PGS has not received different training than the PEPC that better enables them to provide their services in primary care, since the contents of the training curricula of the two are quite similar, which precludes us from a serious discussion opening about the need to enhance the training of psychologists, whether PGS or specialists, to include perspectives that are closer to the budgets of public healthcare and health promotion. A discussion of this magnitude requires another intra-professional climate, far removed from corporate confrontation and with a focus on the good of the profession and the psychological care of the population. However, additionally, the proposed incorporation of the PGS, at present, does not have any real possibilities either. To pretend otherwise would be simple deceit. Many things would have to change. In order from the highest to the lowest difficulty of change, firstly, professional psychological treatment must be provided in this area, secondly, it is not expected to be able to break the preference of the system for hiring professionals trained within it, and thirdly there is a law that prevents it. Given the difficulties in changing the model of mental health care within primary care, I believe that opening this corporate debate is not just useless, but actually counterproductive.

b) The PGS and PEPC are two specialists based on the assumption that the contents of their training program is similar, without subordinating one profession to the other

This is an argument against the training route and should be treated according to at least two perspectives, one legal and the other analyzing the content of the two training programs. The legal perspective leaves no room for doubt. In Spain the title of specialist in the healthcare field is not a generic term that refers simply to the person who develops or practices a particular branch of an art or a science, as the dictionary of the Royal Spanish Academy says, but rather it is an official qualification. Paragraph 1 of Article 15 of the LOPS clearly states that specialized training in health sciences is formal and

official in nature, while Article 16 indicates that its creation or deletion corresponds to the government (proposed by the Ministries of Education and Health and the report of the Human Resources Commission of the National Health System, the National Council of Specialties in Health Sciences and the corresponding collegiate organizations). So when we say that the PGS is a specialist title, for whatever reasons they might be, we are not saying anything that has any legal meaning or effects on the legal regulation of the profession.

In regard to the perspective of the analysis of the contents of the training program, it has been said that those who distinguish between specialist and generalist are committing the sin of nominalism (Carrobles, 2015), i.e. that of the reification of labels, because they are not taking into account the similarities between the two training routes. It is curious that this argument works only one way. If the training programs are the same, then both are specialists, but on the contrary, never is it concluded that both could be generalists. However, there are also those who have perceived (and, from my point of view, rightly so) the specialist training as very generalist (López-Méndez & Costa-Cabanillas, 2013).

From the analysis of the contents, the similarities are obvious (Carrobles, 2015; González-Blanch, 2015) and this seems to be recognized from both perspectives, both in favor of and against the training route. It seems logical that both training programs focus on the same scope of content, as both professions aim to cover the whole field of clinical psychology, so the confluence is logical. However the training has different durations, with the PEPC being four years, compared to the one and a half years of the PGS. It is true that there are other differences in these two training courses, for example they occur in different contexts, although it still remains to be seen whether these different contexts, per se, produce different results in terms of competence (e.g., is the PEPC better trained in the use of evidence-based therapies for addressing depressive phenomena?) The discussion of such matters is riddled with veiled insinuations – the PIR training is poorly controlled (Carrobles, 2013) or the university suffers from a great deal of theory little related to practice (Sánchez-Reales, Prado-Abril, & Aldaz-Armentariz, 2013) - and biased statements that are blind to one part of the reality - for example when the PIR is given as an example of vocational training in comparison with the MPGS, forgetting that the MPGS has 30 ECTS



credits of clinical practice carried out in both public and private healthcare centers (Sánchez-Reales et al., 2013). The discussion thus formulated has no easy solution because there are no arguments that can be tested using empirical evidence. It must be accepted that, to some extent, more time spent in a training period that takes place in a context of greater professional requirement, both due to the contractual obligations and the necessary insertion within a complex multi-profession field, should correspond to a greater ability and professional competence. In this regard, it should be noted that the professional skills are acquired primarily in clinical practice (Roe, 2002). However, it is known that there may be many factors that interfere with this link. If they are known, they must be addressed and the best solution sought. However, from the perspective of professional policy, I consider it particularly harmful to psychology to take as gospel, without any evidence whatsoever, the idea that a longer training duration is irrelevant in improving the professional skills needed. Especially when in scientific terms you cannot set the minimum time for sufficient training, even though this training seems necessary in order to master the therapeutic skills (Wampold & Imel, 2015, pag. 38).

Returning to the previous idea that, rather than two specialties, we are faced with two general professions analyzed at the level of the training content, it is clear that there is a clear tendency of the National Commission of the Specialty to provide the specialists with skills in every conceivable area of psychological action in the healthcare sector, whether by proposing ACEs (areas of specific training) or subspecialties (González-Blanch, 2015), either by increasing the content or increasingly diversifying the rotation plans for residents. There may be several reasons for this. It is possible that the aim is to diversify the performance of the clinical psychologist within the system in order to create the basis for new specialties, and this movement may be fueled by the "expansionist" tendency of other specialties outside of psychology. But trying to cover everything, per se, makes the formation of the specialist "more general" and thus lends some weight to the argument that states that the specialty must "specialize". If other specialties of psychology were established, the relationship between the PGS and the specialists would be less subject to criticism arising from the scrutiny of the programs, and the itinerary would be seen more clearly.

c) The itinerary is contrary to the European standards for the training of psychologists working in the health field. Three topics are discussed here: the Spanish situation is unique because there is only one type of psychologist in Europe that is qualified as a clinician or healthcare professional, in Europe there are no generalist psychologists, and the duration of the proposed itinerary is excessive compared to European standards

As can be seen in the following table (Table 1), there is no European standard. The information was obtained from a report by the European Commission (Comisión Europea [European Commission], 2016), based on the data supplied by the Member States. The claims that there is only one kind of psychologist who works in the field of health and that the official title of health psychologist exists in Europe can be seen to be untrue. Nor is the duration proposed in the training route rare or unusual for the training of a specialist (9 and a half years).

It should be borne in mind that the last four years of training in Spain are paid training, which is a definite advantage from the point of view of equal opportunities and non-discrimination of access to the qualification due to economic reasons. It is difficult to understand that this important fact should be obviated when one argues against the "excessive" duration of the itinerary.

In this regard it should be stressed that the position of the collegial organization has not changed since the specialty was created (COP, 1990). At the time of the creation of the specialty, the collegial organization was in favor of the training that would lead to the specialist qualification lasting 8 or 9 years. It continues to say the same now. Except that half a year has been added, which corresponds to the 30 credits of supervised clinical practice that brings us closer to the old demands of the profession and the EuroPsy.

In this sense, one can say that what does exist with the European range is the common position of the EFPA based on EuroPsy. The EFPA (<http://www.efpa.eu/>) is a European federation of national associations of psychologists that encompasses 36 countries. According to the document, which can easily be found on the Internet (<http://www.europsy.cop.es/>), members of the EFPA have agreed on the standards to be met by the training of the generalist psychologist in order to practice the profession independently and unsupervised. This document states that the minimum training requirement is



five years of university training plus one of supervised practice. This is the generalist training in Spain, which is acquired by combining an ordinary bachelor's degree + master's, as is the case of the Master's degree in General Healthcare Psychology, which satisfies the EuroPsy requirements.

It is worth noting that EuroPsy is not an enforceable directive of the European Union, nor is it related to

postgraduate or specialized training in clinical psychology. It is simply a position common to most of the associations of European psychologists within the EFPA, to which Spanish organizations such as the Spanish Psychological Association have adhered and which inspired the drafting of the white paper on the ordinary bachelor's degree produced by the CDPUE (ANECA, 2005).

TABLE 1
TRAINING DURATION OF THE VARIOUS CATEGORIES OF PSYCHOLOGIST
WORKING IN THE EUROPEAN HEALTHCARE CONTEXT

Country	Healthcare Psychologist	Duration of training	Clinical Psychologist	Duration of training	Psychotherapist	Duration of training
Germany					YES	5 years (multi-disciplinary) + 3 years full time internship
Austria	YES	5 years + 1,940 hours of internship	YES	5 years + 2,500 hours of internship	YES	4 years (multi-disciplinary) + 1,900 hours of internship
Cyprus			YES	6 years – 1,000 hours internship		
Slovakia	YES	5 and 1/2 years	YES	7 years		
Slovenia	YES	4/5 years	YES	8-9 years		
Spain	YES	5 and 1/2 years	YES	8 years		
Finland					YES	3/4 years (multi-disciplinary) + 1 year of internship
France					YES	5 years (multi-disciplinary – medicine and psychology) + 400 hours of internship
Holland	YES	7 years	YES	11 years		
Hungary			YES	8-12 years	YES	5 years + 3 or 4 years of specialization
Ireland	YES	6 years + additional period of internship	YES	7 years		
Iceland			YES	7 years + 3 of internship		
Italy					YES	5 or 6 years (multi-disciplinary – medicine and psychology) + 4 years of specialization
Lithuania	YES	6 years				
Malta	YES	5 years + 2 years of internship	YES	5 years + 2 of internship		
Czech Rep.	YES	5 years + 100 hours of internship	YES	10 years – 400 hours internship		
Sweden					YES	5 years (multi-disciplinary) + 3 of specialization
Switzerland					YES	5 years (multi-disciplinary – medicine and psychology) + 2 years of specialization
U.K.	YES	6 years	YES	6 years		



d) The itinerary is irrelevant because there is no other specialism in the healthcare sciences that requires a master's degree in order to access the speciality

This statement was true initially, until the master's level was awarded to the basic training in medicine lasting 6 years. Anyway, regardless of what happens in medicine and other degrees that give access to the specialties in health sciences, the coherence of access from the master's degree to the PIR training should also be analyzed based on the needs of psychology itself. It seems logical and reasonable that specialized training be accessed from the generalist qualification, which is the master's degree, and it was the extended bachelor's degree, before the reform of higher education. Equating the extended bachelor's degree with the ordinary bachelor's degree is wrong. In fact, recently, the extended Bachelor of Psychology was awarded Level 3 of MECES (Marco Español de Cualificaciones para la Educación Superior [Spanish Qualifications Framework for Higher Education]), which is the level of a master's degree (Ministry of Education, 2015).

This argument includes another comparison that does not seem quite right. Clinical psychology is not equivalent to the FIR, BIR or QIR more than in name, as specialists in the health sciences. Each of the BIR, FIR and the QIR are typically destined to extremely important multidisciplinary services within such a modernized medicine as the current one, but they do not include among their competencies the diagnosis, evaluation or treatment of patients. They are professionals that integrate highly specialized technical services but they are not "clinicians". This difference would justify, per se, that the access to the specialist post had guaranteed sufficient knowledge for basic clinical practice, and the knowledge and skills would be acquired in the master's degree in general health psychology.

e) The itinerary hinders the training of psychologists, significantly reducing the supply of graduates in the face of the great social demand of psychology

The idea that is deduced from this statement is that a fast system of training of psychologists is required to cover an alleged broad social demand. The high rate of unemployment among professional psychologists, with 26.6% of them unemployed or inactive according to the latest INE survey of employment (Instituto Nacional de Estadísticas [National Institute of Statistics], 2016), invalidates the main reason for this argument.

Although it seems clear that the number of professional psychologists in the health sector has not yet reached the European average of employment in the public sector (WHO, 2014), the fact remains that healthcare administrations face severe budgetary constraints that make it difficult to reach the European medium-term average figures. There is no indication that an offer will be opened up in the foreseeable future of clinical psychologist places that cannot be met with the existing qualified professionals and training procedures.

Moreover, the duration of training should not be related to the alleged need to produce professionals faster, but rather with the time necessary to acquire the skills required. No one has detected a demand for professionals that cannot be satisfied. If the time required to train a specialist in clinical psychology is 9 and a half years, then that is the time that must be devoted to the training.

f) The existence of two qualifications, the PGS and the PEPC, requires the strict delineation of the functions and areas of practice

It seems reasonable that the creation of a new healthcare profession must come coupled with a legal framework that clearly describes the contents of this profession and its respective training regulations and practice (Sánchez-Reales et al., 2013). However, it must be remembered that these legal requirements are contained in the provisions that create and develop both the PGS and the PEPC. Except for the unjustified restriction of the PGS from the public health system, this regulation is no different from that in other healthcare professions.

There is no strict demarcation of functions in the other profession that has a generalist degree and other specialized ones within the healthcare field, i.e., medicine. Therefore it is not understood why the existence of the PGS and PEPC requires the strict delineation of functions that goes beyond what is already regulated, if to date medicine has been able to develop within the same situation without major problems. It is not hard to see how this task could be accomplished and who would benefit if it were carried out. The LOPS is positioned against this, as the Supreme Court points out in its judgment of 25 October 2011, when it states in Article 9 that "Comprehensive health care is a multidisciplinary cooperation, the integration of processes and continuity of care, and it avoids the splitting up of or the simple



overlap between care processes attended by different graduates and specialists." This is the opinion that the collegiate organization has always maintained, and the main reason that drove it to appear in court against the ANPIR appeal against the decree/order creating the master's degree in PGS, which inexplicably seems to be forgotten in some cases (Carrobes, 2015).

Among those who advocate the idea of the division of functions, it seems to be commonly believed that the PGS is not able to treat mental disorders, which in some cases have come to be generically called "serious mental health disorders." This is the essential dividing point. The reason is the longer training of the specialists in such problems, or the necessary specialization of the PGS in the healthcare field. It may be granted that specialists have greater skills for dealing with what are considered to be serious problems, due to their longer training duration in mental health settings where they are more frequent and the skills are mainly acquired in practice (Roe, 2002). However it is also clear that these are not exclusive skills. As for the alleged lower training of the PGS in mental disorders, one only has to look at the course curricula to see that this idea is wrong.

But it is more than this: relating a disorder with a "serious problem" is clearly an oversimplification. In a document issued by the CDPUE and the Spanish Psychological Association to the Ministry of Health, in response to a well-known written document from the General Sub-direction of Academic Planning, which establishes an analogy between a "serious problem" and having the label "mental disorder" and hence concludes that the PGS cannot deal with these complications, the following is stated:

"A first interpretation could mean that the document means that all disorders are serious disturbances of mental health, and therefore, the people who present them must necessarily be attended by the psychiatrist or psychologist specializing in clinical psychology. This interpretation is not acceptable for two reasons. The first is that the severity refers to the episode rather than the disorder, which may have a variable course in reference to the "severity" of the symptoms. The division sometimes used between common and serious disorders must not make us lose sight of the dynamic and evolving nature of the idea of a disorder. In this perspective, the course of most disorders enables us to determine variable episodes of symptomatology, impact and prognosis, which makes it completely inappropriate to

link a unique concept of severity to the constellation of manifestations of a disorder. Secondly, from this interpretation it appears to be deduced that the aforementioned specialists possess these skills exclusively, and therefore they cannot be practiced by the general health psychologist. However, this interpretation does not comply with the existing legislation, because as we described previously and the state attorney himself noted, representing the Government, in the current regulations there is no such exclusive allocation of powers, and the general health psychologist can actually attend to people suffering from disorders.

A second interpretation would be that serious mental health problems that do not reach the categorization of disorders according to the existing international classifications, such as a confusional syndrome or severe psychotic disorder that does not reach the time threshold established in its course, could actually be treated by the general health psychologist. This interpretation does not seem to be of good judgment, since it could occur that this serious problem exceeds the skills of the general health psychologist who is not able to address it effectively, so it would be appropriate to refer the case to another professional.

A third interpretation might suggest that the disorders that present serious behavioral problems are those that must be addressed by the psychiatrist and psychologist specialist in clinical psychology, while disorders involving mild to moderate problems can be attended by the general health psychologist. Leaving aside the difficult estimation of the concept of severity, which encompasses multiple components, this interpretation has a major problem, which is the union of the assessment of severity with the idea of disorder. Who can attend mild and moderate problems of disorders that may cause serious problems? As previously noted, the severe, moderate or mild nature must preside more over the episode than the disorder, so there may be severe episodes in common disorders or mild to moderate episodes in the disorders considered to be more serious (Consejo General de Colegios Oficiales de Psicólogos [Spanish Psychological Association] & Conferencia de Decanos de Psicología de las Universidades Españolas [Conference of Spanish University Deans], 2015).

I fully subscribe to the contents of this letter. But also, it is not without irony that it is in psychology, one of the harshest critics of the entity of the concept of disorder,



where it is proposed that this is the dividing criterion for the delimitation of professional skills. How is it possible that, although this is one of the disciplines that has most advocated a dimensional and transactional vision of psychological problems, we are mired in a debate about whether these entities can be seen only by one or the other type of professional?

THE BALANCE OF THIS REGULATION. IS THIS REGULATION CONVENIENT TO PSYCHOLOGY?

As we already said, the regulation of psychology is poorly planned and lacks the necessary coherence. It is a regulation that has been carried out in reverse to the way it should be done. First the specialty was regulated in a context where the extended bachelor's degree in psychology was regulated, i.e., it was part of the catalog of qualifications and the profession also had some degree of regulation, the title was protected, and attachment to the collegial professional association was required in order to practice the profession. Since the creation of the single title of specialist no other specialty has been created, a serious drawback for a discipline like psychology with multiple fields of intervention. Next the generalist training was regulated through the master's degree in general health psychology. This regulation coincided with the deregulation of the title, when the extended bachelor's degree and catalog of qualifications disappeared. For that reason, the very law that created the master's degree forecast the regulation of the ordinary bachelor's degree. The lack of regulation of the ordinary bachelor's degree, even now, is what has led the administration to indicate that the specialty be accessed from an ordinary bachelor's degree in the "field of psychology" or that the provision is not met that the contents that give access to the master's degree are defined. In this regard, it is truly absurd that the administration insist on using the term "in the field of psychology" based on the lack of regulation of the ordinary bachelor's degree, when it is more than evident that the existence of an ordinary bachelor's degree in psychology, a denomination contained in the teachings offered by the universities and in the qualifications produced by the state itself, provides more legal certainty than the phantasmagoric reference to an ordinary bachelor's degree in the "field of Psychology", a pipe dream that nobody knows of, or understands its meaning.

Both the PIR and the master's degree are accessed from

the ordinary bachelor's degree, without there being any connection between the two forms of training. This favors a dual model of intra-professional competence due to the places where it is carried out, as it is currently viewed. Until now, attempts have been made to reduce this source of conflict through the legislation that prevents the PGS from accessing the public system. But that is a form of control with a flimsy justification, as mentioned earlier. Another source of conflict is the increasing questioning of the specialty through the argument that both the PGS and the PEPC are specialists. This scenario of growing hostility has sometimes been seen as good for society, since it promotes competition among the professionals. I cannot disagree more. This corporate bickering does not affect the quality of services but rather it constitutes the conflicts of professional power that detract resources from where they must be placed, on the development and improvement of the profession and science of psychology. The invisible hand of the market that seems to be alluded to by those who wish to promote intra-professional competition, is not a good idea when it affects people's health or safety. The cause of this conflict lies, in our case, in the regulatory rigidity of the administration which is not sensitive to the needs of our profession and regulates according to the whim of the moment, with little or no view of the bigger picture. In this sense, the growing disconnect between the two qualifications, the PGS and PEPC, can only be solved through the logical sequencing of training, such that the master's graduates have exclusive access to the specialized training, and a greater diversification within the specialization. Thus, one would think that, each at their own level, the two qualifications would be seen within a single professional sphere and not as external entities that are fighting over the same space.

One of the effects of this dual training is the different involvement of the universities in training the professionals. In the MPGS the training is university-based from beginning to end, as it was with the extended bachelor's degree, but with the difference of the presence of regulated clinical practices that enable students to begin to maintain contact with the professional world, both public and private. In the case of the PIR, the training is conducted in care units with teaching accreditation, which are completely external to the university, since there are virtually no associated places in the field of psychology.

I firmly believe that the ideal training in the field of clinical psychology must conform to the Boulder model



adopted by the American Psychological Association in 1949, whose main rationale is that clinical psychologists have to acquire not only the professional skills needed to assess and treat patients according to the highest professional standards of quality, but also the scientific skills that allow them not only to be critical of the practices of psychology but also to carry out research based on clinical practice. This goal is not easy to achieve for psychologists that are located within multidisciplinary teams, almost always alone, pressurized by an overwhelming demand for their services, and whose career does not depend on their ability to investigate and innovate. All of this takes place in a context where research is not a priority, and psychological research even less so, given the predominance of the biocentric model primarily funded by both private and public money. In a situation similar to the one described here, which took place in the UK, it was proposed that a strategy to overcome these difficulties would be through collaboration between the psychology services of the NHS (National Health Service) and academic clinical psychologists working in universities (Shapiro, 2002). The types of cooperation may vary, but I think that in our country the best method is to link teaching positions in clinical psychology with care posts. Thus stable and enduring ties can be established that favor the development of clinical psychology in our country by promoting research, developing new forms of organization and clinical psychology work in our health care system, strengthening prevention and health promotion in clinical centers, promoting and improving interventions for children and young people, searching for new forms of intervention to reduce stigma and improve the empowerment of families and caregivers, and in many other fields in which worrying deficiencies can currently be seen. Many of these objectives are also the goals that European research in mental health must prioritize (Wykes et al., 2015). In the absence of empirical studies that may have more validity and reliability, I have the impression that the research comes mainly from the faculties, while there are scarcely any, with notable exceptions, research activities from the professional field. The professional scientific organization of Spanish clinical psychology, segmented in diverse and fragmented professional and scientific societies, suffers from a chronic inability to develop initiatives that are level with the number and quality of professionals practicing the profession. I believe that, in order to reverse this state of

affairs, the Spanish university cannot see the specialty of clinical psychology as external to it, and the specialists within the public system must see academic clinical psychology as part of their own profession, without which they lose an important part of their identity as professionals. Specialists at the master's stage could acquire research skills, within university research groups, which could then bear fruit significantly at the time they reached the care units.

Finally, as well as enhancing the intra-professional conflict in a way that is of no benefit to anyone, this duality reduces the chances of improving both qualifications significantly. On the one hand, as has been reiterated on several occasions, the position of clinical psychologists in the public system depends on a specialist training plan that cannot ignore what is happening in the other professions with which it collaborates competitively. The association between the ideas of collaborating and competing may sound strange, but that is what is happening in the current healthcare system where the psychologist is part of teams that aim to support and collaborate for that purpose, but in which other important issues are also settled competitively, such as the control of healthcare resources, access to clinical and management decision-making positions, the ability to lead projects of innovation or to direct the teaching, etc. In these conditions one should strengthen the current position, not weaken it. Connecting the MPGS with access to the PIR means improving the qualifications of those who access the specialty. This connection would keep the length of specialist training within the range that always was considered acceptable by the psychologists themselves, and would place it on an equal footing with other specialties with which it collaborates and competes. Furthermore, since the PGS has different conditions than the ordinary bachelor's degree, there could be a selection mechanism for the PIR to improve the current conditions, which clearly have room for improvement, and taking into account fundamentally their skills and abilities for carrying out the profession of clinical psychologist.

For the MPGS, exclusive access to the specialist training would be a clear advantage. It would provide the option to be specialists with tighter demand and supply ratios for PIR places than the current ones and the PGS would not find themselves in the situation of ordinary bachelor's graduates in psychology who have to pass the PIR examination or end up with nothing. In addition,



professional integration could be an opportunity to reduce the intra-professional hostility and reach mutually beneficial agreements, which could include a common position on the role of the PGS in the public system. For example, there are areas of public health in which psychologists can play an important role and these could be covered by professionals such as the PGS.

From everything said so far it can be said, in summary, that the current situation of the regulation of clinical psychology presents grey areas, which could be improved by simply reforming the access to the specialty. The benefits far outweigh any inconvenience, and the legal reform to change the situation can be arranged quickly and easily.

A proposal: the training route. What it solves and what it does not solve

The adoption of the training route has undoubted advantages over keeping things as they are. Some of the advantages of establishing the ordinary bachelor's degree-master's-PIR sequence would be as follows:

- 1) The unit of clinical psychology is maintained, establishing a career in which progress is punctuated by a sequenced accumulation of knowledge and skills. This unit can help overcome the current fragmentation and reduce the existing divisions that hinder the development of a strong science and profession. The energy currently being spent on infighting could be channeled towards establishing a strong scientific and professional society that would guarantee the continuous and demanding development of clinical psychology.
- 2) It reduces the intra-professional conflict since all psychologists working in clinical psychology share a common project. It is possible that by reducing the time and effort spent on internal fighting, the PEPC and PGS can focus on developing proposals to provide more and better psychological services to our health system, whether public or private.
- 3) The route will bestow added value to the realization of the MPGS, since only the holders of that qualification may sit the examinations that give access to the PIR, but it will also reduce the ratio of applicants per specialized training place, and streamline the decisions of ordinary bachelor's graduates in psychology. For every specialized training position today there are 30 candidates who apply, which means that 29 will not get what they are aiming for after having spent two or

three years training in private academies in order to achieve it. Those 29 cannot practice in the healthcare system because they do not have a qualification that will allow it. This is time and money spent to no avail, during a critical period for the employability of the graduate. This waste of resources makes no sense. It would be logical that, if they were unable to access any of the 2,200 master's positions that were offered in 2016, the graduate would opt for other professional areas of psychology, and not continue spending resources on an option with where the odds of success are 30-1. Only those who maintain the same distortions of thought that are characteristic of pathological gamblers would maintain otherwise.

- 4) It will reinforce clinical psychologists within the healthcare system, with a training program homologous to that of other mental health professionals with whom they work and compete.
- 5) The fact that the MPGS is the gateway to the PIR training will mean a greater connection among the clinical psychologists working within the public system and the university psychology departments. This will be achieved in various ways. Firstly, by involving clinical psychologist specialists working more intensely within the public healthcare units in the teaching of the master's degree. There is no doubt that if they see the master's degree as their own they will be more motivated to participate and improve their teaching. Secondly, this greater involvement of the clinicians may mean greater incentives and possibilities for conducting joint research, either through the final master's project, or by promoting broader research projects and doctoral theses. Finally, one would think that this dynamic interaction should lead to an increasing tendency to create associated positions, so that the participation of clinical psychologists would be increasingly stable, but there would also be the presence of senior professors and lecturers in subjects of clinical psychology at healthcare centers. The formulas can be varied and adjusted to the specific needs of academic and professional psychology.
- 6) Only with a cohesive profession can major challenges be addressed. The legal limitation of the PGS in the public healthcare system should be eliminated slowly but surely. This task should be carried out without prejudice to the rights of the specialists and the public to receive the best care with the highest level of skill. But



also with the idea that a specialist, by definition, is not an expert in everything, and that there are areas of public assistance that, in the absence of a specialist, could be covered by generalists until they develop and establish their own specialties. Other challenges, such as the introduction of clinical psychology into primary care or the creating of psychology services in hospitals to give coherence to the psychological services currently scattered around in various hospital departments, may also be important goals that will only be achieved if our energy is projected outward and not inward of the profession.

Clearly there are other important issues for Spanish clinical psychology that are not resolved with the training route but which do not negate it either. Repeatedly mentioned in various studies is the mismatch between the supply of graduates who want to train in clinical psychology or psychologists who are already accredited to practice in the healthcare field seeking employment, and the respective places of training and work. This disproportion has no solution other than a very significant decrease in the number of graduates and also a very significant increase in the opportunities for training or work. However, I will not go into the analysis of the factors that come into play. I simply wish to point out that the training route is neutral on this matter, since the disproportion is established between the performance obtained from the resources devoted to training and those devoted to care in mental health. In our case, it is well known that psychology is seen by the universities as a profitable career, since there is a high demand for enrollment at a good price, together with a very low investment in implementation, compared to other qualifications in health sciences. This means that there are now between 50 and 60 thousand psychology students in Spanish universities. Meanwhile investment in mental health, and within mental health in psychological services is extremely low, and it does not seem to be growing. Moreover, we are well below the European average (OMS, 2014). But even if we reached the European average, it would be impossible to balance the input and output without a drastic reduction in the former. In this case, I do not see how the training route can influence this.

Neither can the training route, per se, be an antidote to the associative fragmentation of clinical psychology, the low implementation in public healthcare services, the funding shortages in mental health research, the crisis of the diagnostic systems and the consequent drift towards a

model of greater integration in the neurosciences (Tortella-Feliu et al., 2016) or many other problems, some of which I have already mentioned and others I have not.

However, without a doubt, a more cohesive clinical psychology, without internal wars that have no beneficiary and with all its energy directed at making the science and profession bigger and better, can be a tool for change with scientific, professional and social influence. The results will be better for psychologists, but also for the recipients of our work and for society itself, as a whole.

AUTHOR DISCLOSURE STATEMENTS

No competing interests exist

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