



CLINICAL PSYCHOLOGY AFTER THE PGS (GENERAL HEALTHCARE PSYCHOLOGY) IN SPAIN: A REASONED PROPOSAL

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From now on, for the independent practice of psychology in the field of health in Spain, the psychologist must complete the newly created Master's degree in General Healthcare Psychology. However, this mandatory university course is not required for access to the specialised healthcare training that provides the title of "clinical psychologist" (the PIR, an internship in Clinical Psychology). In this paper we argue in favour of changing the access to the specialised training program in clinical psychology so as to ensure that the knowledge and skills specifically related to healthcare offered by the university are included in the curricula of future clinical psychologists. Finally, the risks to the entire profession of impoverishing the university studies of clinical psychologists are discussed.

Key words: Clinical psychology, General healthcare psychology, University studies, Internship in clinical psychology, Legal regulations.

A partir de ahora, para el ejercicio independiente de la psicología en el campo de la salud en España, es preciso cursar el recién creado máster en Psicología General Sanitaria. Sin embargo, esta formación universitaria obligatoria no se exige para el acceso a la formación sanitaria especializada (el sistema Psicólogo Interno Residente, PIR) que permite obtener el título de psicólogo clínico. En este artículo se argumenta a favor de modificar el acceso al programa de formación especializada del PIR de modo que se garantice que en el currículo del futuro especialista están los conocimientos y habilidades más específicamente sanitarios que ofrece la Universidad a los psicólogos. Finalmente, se exponen los riesgos para el conjunto de la profesión de empobrecer la formación universitaria de los psicólogos clínicos.

Palabras clave: Psicología clínica, Psicología general sanitaria, Estudios universitarios, Psicólogo interno residente, Regulaciones legales.

The reform of university curricula to adapt to the framework of a European Higher Education Area (EHEA) has led to a reduction in the number of years of studies in psychology. The result has been a new bachelor's degree of a multipurpose nature with a duration of four years. Today these studies do not enable the graduates to work independently in the health field. Instead it is compulsory to undertake a master's degree covering content specifically related to health with a period of supervised practice which gives access to the official

qualification of General Health Psychologist (PGS), created by an additional provision of Law 33/2011, of October 4, on General Public Health (BOE, no. 240, of October 5, 2011). According to its advocates, a generalist health degree in Psychology was necessary to give legal cover to the activities in the health field for the (future) psychologists who will practise, mainly in the private sector, without a specialist qualification.¹

Unfortunately, this process of creating the PGS has ignored the figure that was already recognised as a health practitioner in this branch of psychology: the clinical psychologist. The result is that, since there is now a university education specifically related to health for psychologists, the clinical psychologist has ended up with a university education that does not encompass healthcare. On the other hand, without an adequate link between the training of the generalists and the specialists, the coexistence of the two figures is exposed to undesirable conflicts and confusions. This article aims to argue in favour of the proposal to amend the curricular itinerary of the clinical psychologist so that the new generalist qualification is required for access to the

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¹ Contrary to what happened with the specialist qualification, no extraordinary pathways are foreseen for accessing the qualification of PGS. Instead, established by Law 3/2014, of 27 March (BOE, no. 76, 28 March 2014), an authorisation has been provided to enable psychologists with undergraduate or postgraduate training in the field of clinical psychology to work in health centres.



specialist training, as it is required for other psychologists who aspire to work as healthcare professionals.

THE REGULATION OF PSYCHOLOGY IN THE FIELD OF HEALTH IN EUROPE

Mental health is an essential and integral part of health. The right to health protection is recognised in the Spanish Constitution and, above it, in the Universal Declaration of Human Rights. The regulation of health professions, either through the creation of qualifications or professional associations, is primarily intended to ensure that the professionals meet the skill levels required to safeguard the right to health protection. To achieve this, it is essential to control the quality of their training and to facilitate the identification and recognition of professionals.

Most European countries have addressed the regulation of psychology in the health field, however, this regulation has been far from uniform. On the contrary, there are different regulatory models each with their own criteria for recognition and their own regulatory authorities. Some regulations occur at the level of state law (as in Spain), whereas in others, it is at the level of regional law (as in Switzerland) and others are controlled by professional associations (as in the UK). The regulated qualifications are also different: psychologist, licensed/accredited psychologist, health psychologist, clinical and health psychologist, clinical psychologist, and psychotherapist (Van Broeck & Lietaer, 2008). Within the marked heterogeneity of this situation, there are at least two common elements in countries that have already regulated the training requirements of the psychologist in the health field. Firstly, the minimum training for independent professional practice of psychologists in this field has a level that is equivalent to that of a master's degree. Secondly, a period of supervised practice is required. In some cases this is included in the university curriculum and in others it occurs afterwards.

It is worth mentioning that being qualified to work in a field is not equivalent to being a specialist in it. With regards to the speciality in clinical psychology, the situation is equally as heterogeneous or even more so. There is no European speciality as such, and the countries where it does exist are in the minority and have marked differences between them. According to a survey conducted at the end of 2005 among the presidents of European associations of psychologists, only 7 of the 24 countries surveyed had a speciality in clinical psychology that was legally regulated and, of these, only four

countries had a system of specialised training similar to that of the Internal Resident Psychologist (PIR), here in Spain: the UK, Italy, Sweden and the Netherlands (Berdullas Temes & Fernández Hermida, 2006).

PROBLEMS FOR THE REGULATION OF PSYCHOLOGY IN SPAIN

Twenty-one years have passed between the national implementation of the system of specialised intern-resident training for psychologists (the renowned PIR) in 1993 and the recent authorisation of psychologists with some training or experience in the health field to work in health centres. This excessive delay has been one of the main causes of the problems and conflicts that we healthcare-oriented psychologists have suffered. For a long time there has coexisted a regulated way to access the specialist qualification together with the previous situation in which any psychologist, with or without specific training in the clinical setting, could call him or herself a clinical psychologist and practise as such (which meant, for example, that they could benefit from the VAT exemption applicable only to "clinical psychologists" [sic] according to the Resolution of September 2, 1991, of the Directorate General of Taxes [BOE, no. 253 of October 22, 1991]). Absurd anachronisms have occurred, such as psychologists completing their PIR training when the qualification that this should give them access to did not actually yet exist. The delay in obtaining the qualification through the transitional pathways has not helped. The Ministerial Order developing Royal Decree 2490/1998, of 20 November, which creates and regulates the official title of Specialist Psychologist in Clinical Psychology (BOE, no. 288, December 2, 1998) was delayed for four years, and three years later the time limits were extended, which allowed a greater number of psychologists to obtain the qualification through the transitional pathways. Together, nearly 10 years went by from the moment the process of the transitional pathways opened until it finalised, although there was no shortage of attempts to reopen it and even to cancel it as a whole, for example, with a ludicrous criminal complaint filed against the members of the National Commission of the Speciality of Clinical Psychology (CNEPC in Spanish) for prevarication and forgery of documents, a complaint which was not accepted for processing and was dismissed. Finally, it is perhaps contrary to logic that the speciality was regulated first and then, two decades later, the necessary generalist training to practise in the same branch was established.



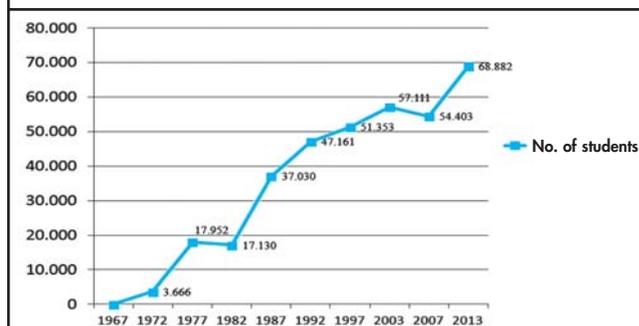
In addition to the delay in the legal regulation, one of the main reasons for the difficulties encountered in this long process of organisation is related to the massification of psychology studies and, consequently, of graduates. Figure 1 shows the dramatic rise in the number of students enrolled since psychology acquired the status of a university qualification in 1968. The uncontrolled growth since the mid-seventies has been described as "probably the greatest growth in the recent history of the Spanish University" (Blanco & Botella, 1995) and, since then, new psychology faculties have not ceased to open, mainly private ones. This is the case even though the National Agency for Quality Assessment and Accreditation (ANECA in Spanish) itself acknowledged in the *White Paper on the Qualification of the Bachelor's Degree in Psychology* that "the volume of students and professionals in psychology in Spain is clearly greater than the possibilities of insertion into the job market" (Agencia Nacional de Evaluación de la Calidad y Acreditación [National Agency for Quality Assessment and Accreditation], 2005, p. 65), 2005, p. 65) or, in the words of the President of the General Council of Psychologist Associations (COP), "it exceeds, by far, any possible expectation of employment" (Santolaya Ochando, 2005, p. 116). Currently, for every licensed psychologist there is more than one student (statistically speaking). For every nursing or medicine student, prototype careers in the health sciences, there are 15 and 9 licensed professionals, respectively. It is not that there are few psychologists; in fact, this is probably the country with the largest number of psychologists per capita in the world (Van Der Vlugt, 1998). According to data from the Ministry of Education, 8,206 students completed their studies in the year 2012-13. It is estimated that 60-70% are clinically oriented, that is, about 5,000 graduates a year hope to work in a field that should have around 2,000 psychologists employed in the public sector and, according to the preliminary data, 8,000 psychologists who provide assistance in various environments of psychological intervention in the private sector, mainly in single-practitioner consultancies (Pastor Sirera, 2008). The result is that, according to the Public Employment Services (SEPS in Spanish) in November 2014 there were 21,344 psychology graduates applying for work, of

whom 14,808 were unemployed. To these, we must add 915 graduates seeking employment, of whom 685 were unemployed (SEPE, 2014). The hypertrophy of academic psychology and its consequences in the form of unemployment and underemployment, is a key factor in the difficulties encountered in the organisation of the profession.

If the massification of studies or, at least, the clinical orientation of the majority of the students is not rectified, the current regulations may be useless for the organisation of the profession. There is nothing to exclude the arising of alternative forms of official accreditation for employment (or underemployment) in this field, either under the name of psychologist but in centres without healthcare registration, or with new names.² The professional associations will continue to have the dilemma of either fulfilling their statutory duty to organise the profession or offering specious alternatives to an oversized mass of members in which the votes of those who practise are rightly worth the same as the votes of those who do not.

Whether deliberately or not, the institutions of psychology often mitigate this problem of overcrowding by emphasising the scarcity of public resources dedicated to psychological care. A working group of the COP in Valencia produced a report which estimated that in the Spanish National Health System (SNS) 20,000 psychologists were needed in Primary Care (PC). The

FIGURE 1
EVOLUTION OF THE NUMBER OF REGISTERED PSYCHOLOGY STUDENTS FROM 1967-68 TO 2012-13



Sources: Hernández Gordillo (2003), Instituto Nacional de Estadística y Ministerio de Educación, Cultura y Deporte [Spanish National Institute of Statistics and Ministry of Education].

² For example, "coaches" have gained rapid acceptance by some psychologists associations, although this poorly defined practice causes confusion with the professional profiles of psychologists in the fields in which they have played a specific role for years: the clinical, occupational, educational, social, and sporting fields, etc.



Spanish Society for the Advancement of Clinical Psychology and Health, 21st Century (SEPCyS in Spanish) used this rounded figure in a statement to justify the need to include non-specialist psychologists in PC; the Board of Governors of the COP Valencia adopted it and circulated it (SEPCyS, 2011). Recently, in a debate organised within a SEPCyS conference (Almería, October 2014), Professor José Antonio Carrobes added to the 20,000 psychologists in PC, another 8,000 professionals for specialist care (i.e., all of the accredited clinical psychologists in Spain plus another 20,000 professionals). These figures may match the dimensions of academic psychology, but they are completely ludicrous if we look at the reality of the SNS. According to the report on the need for medical specialists in Spain (Barber Pérez & González López-Valcárcel, 2009) no speciality, with the exception of Paediatrics and Family Medicine, has more than 5,000 professionals working in the SNS. With 20,000 psychologists in PC there would be more than one psychologist for every two family doctors. Paediatrics, which attends to all patients under 18, both sick and healthy, had less than 10,000 professionals at the end of 2008. Then there were *only* 2,618 psychiatrists in the SNS. One only needs to look at the SNS data to realise how unsubstantiated and preposterous these estimates are with regards to the need for (clinical) psychologists, not just in the current circumstances of economic crisis, but in any conceivable circumstance.

WHAT IS CLINICAL PSYCHOLOGY AND THE PGS?

The conceptual and practical definition of clinical psychology is extremely complex. The definitions proposed by experts and institutions are necessarily broad (see Fernández Molina, 2003). For example, we could mention the definition proposed in the technical report *Base Document for the postgraduate training of psychologists specialising in Clinical Psychology through the PIR system* developed by a committee of experts in 1988 to determine the basis of the training of specialists in clinical psychology through the PIR: "Clinical Psychology is a speciality of psychology that deals with human behaviour and psychological and relational phenomena of health and disease in the field of mental health in various aspects of study, explanation,

promotion, prevention, evaluation, psychological treatment and rehabilitation, understanding health in its comprehensive sense (biopsychosocial), all of which is the result of clinical observation and scientific research, covering the different levels of study and intervention: the individual, couple, family, group, and community, and this in relation to the specialised level of mental health services" (Colegio Oficial de Psicólogos [Psychological Association], 1990). This report was signed by the State Board of Governors of the COP and the various COP delegations at the time.

This and other related definitions are consistent with the professional practice of clinical psychologists, carried out in multiple contexts. Consistent with this broad conception of the speciality, the training program of the PIR, updated in 2009, as the basis for training clinical psychologists, establishes rotations (internship periods) in the various mental health services and units, other hospital specialities and PC. The possibilities of the Teaching Unit and the interests of the resident or intern configure the sequence of the rotations which, preserving the basic and common content, may differ in the specific contents between some hospitals and others, as well as between some residents and others. In short, any field in which clinical psychologists have been carrying out their professional work is potentially part of the PIR program.

Regarding the new MPGS training program, the only information available is in Order ECD/1070/2013, of 12 June, laying down the requirements for the authentication of official university master's degrees in General Health Psychology (BOE, No. 146 of 14 June 2013) and the first syllabuses published by the universities that will impart this course. The master's degree consists of 90 European credits³ of content that is specifically related to (mental) health, distributed in modules of compulsory and optional subjects, of which 30 correspond to classroom practices. The aforementioned Order establishes the general rule that students must acquire the knowledge and skills necessary to carry out psychological research, evaluations and interventions on the aspects of people's behaviour and activity that influence in promoting and improving overall health, provided that such activities do not require specialised care from other healthcare professionals.

³ One ECTS European credit (European Credit Transfer System) is equivalent to 25 or 30 hours of work, which includes, in addition to the teaching hours, other more difficult concepts to quantify, such as the effort devoted to study or preparing and taking examinations.



It could be understood that, with this training, the clinical branch of psychology studies retrieves and reinforces, with the contents of the previous postgraduate courses in Clinical and Health Psychology, the year that was lost from the old undergraduate degree, which in many universities consisted of three core years and a final two in which you could choose from several optional subjects that formed the "clinical speciality". While it may be argued that the master's degree improves the previous degree, the subjects have similar names and even, in some cases, the same teachers... In any case, it is understood that the subjects are a vital part of the university curriculum for any psychologist that wishes to work in the world of healthcare. The implementation of the internship is the most notable advantage over the training offered in the old undergraduate degree. A minimum supervised practice is, as mentioned before, a basic requirement for independent practice wherever the practice of psychology has been regulated in the field of health.

The analysis of the subjects in all of the master's degrees offered shows that there is no distinct profile with respect to the field of clinical psychology. Although there are notable differences between the syllabuses of the various universities, the typical subjects cover the assessment and intervention of various mental disorders (addictions, dementia, psychotic disorders, affective disorders, anxiety, eating behaviour, sex, sleep, personality, etc.) In fact, the maligned Diagnostic and Statistical Manual of Mental Disorders (DSM) seems to be the central pillar of these syllabuses. Only some include subjects which, due to their social-healthcare nature, could be of particular interest to a profile complementary to that of the specialist, for example, psychosocial rehabilitation, health promotion, substance abuse, early intervention, domestic violence or emergency intervention. But the weight of these subjects is relatively less. It is also worth noting that, contrary to the interpretation some professors have given to these studies (e.g., Carrobles, 2012; López Méndez & Costa Cabanillas, 2013), they are not syllabuses that are specifically aimed at training in the field of health psychology. On the contrary, the compulsory and optional subjects related to this field are a miniscule part of the whole set of syllabuses. The syllabuses usually

include a general subject related to health psychology but, for example, psycho-oncology, a prototypical subject of this discipline, does not appear as a separate subject in the syllabus of any of the surveyed universities.⁴ Moreover, it is highly questionable, in the reality of the Spanish professional situation, to claim that the work of health psychology has not been carried out (or does not continue to be carried out) by clinical psychologists. In fact, accreditation as a clinical psychologist could be earned by working in this field through the transitional pathways of Royal Decree 2490/1998, of 20 November, which creates and regulates the official title of Specialist Psychologist in Clinical Psychology (BOE no. 288, December 2, 1998). It would be incongruous in this context to affirm now that this is not the work of clinical psychologists. All of the above is without prejudice to the (sub)specialities that may be created in the future.

THE DIFFERENCES BETWEEN GENERALISTS AND SPECIALISTS

From a legal perspective, the qualification of specialist is required in order to use the name of specialist and to practise as such in the profession (Law 44/2003 of 21 November, regulating health professions [BOE, no. 280 of November 22, 2003]), university degrees may not lead to confusion or coincide in name or content with specialist qualifications (Royal Decree 1393/2007 of 29 October, which establishes the organisation of official university teaching [BOE, no. 55, on March 5, 2014]) and cannot have the same professional effects (Royal Decree 183/2008, of February 8, which determines and classifies the specialities of Health Sciences and certain aspects of the specialised healthcare training system [BOE, no. 45 of February 21, 2008]). The reader can judge for themselves whether the regulations are being met. The National Association of Clinical Psychologists and Residents (ANPIR) has filed an appeal against Order ECD/1070/2013 establishing the requirements of the MPGS, understanding that it contravened the regulations that safeguard the speciality (Asociación Nacional de Psicólogos Clínicos y Residentes [National Association of Clinical Psychologists and Residents], 2013).

The same laws that produce the figure of the PGS establish another difference: psychologists that carry out

⁴ The syllabuses reviewed correspond to those taught at the Universidad Autónoma de Madrid, Universitat de Barcelona, Universidad de Córdoba, Universidad de Granada, Universidad de Málaga, Universidad de Sevilla, Universidad Rey Juan Carlos and the Universidad Pontificia de Salamanca.



their activity in centres, establishments and services of the SNS or in public-private partnerships with the SNS must hold the qualification of specialist. To judge compliance with this point, it will be necessary to wait a few years. For now psychologists working in the SNS before March 2011, with or without postgraduate training or supervised practicals, have been authorised to practise as healthcare workers according to the eighth final disposition of Law 3/2014, of March 27, approving the revised text of the General Law for the Protection of Consumers and Users (BOE, no. 76 of March 28, 2014).

At the level of program content, despite the affinities mentioned, there are important differences that must be emphasised. The PIR intern, who accessed the position via a public examination, is hospital personnel with a full-time employment contract of four years duration (and here we cannot evaluate the intern's considerable effort and dedication outside working hours). He or she receives a phased supervision in different workplaces within the speciality and has different clinical psychologists as supervisors. During that time, like the rest of the medical staff, the intern manages healthcare documentation (accesses medical records, writes notes on the consultations, produces clinical reports, etc.) and, under supervision, he or she makes clinical decisions (on evaluations, treatments, discharges, transfers, etc.). The theoretical training, which constitutes about 20% of the time on the program, is taught primarily in the form of clinical sessions, bibliographic sessions and seminars. The intern can also carry out a portion of his or her training (up to 4 months per year) in other prestigious centres in Spain or abroad, while still being paid.

The psychologist who undertakes the MPGS is a university student who has accessed the studies by the selection criteria fixed by the university department in each case. The external practices are equivalent to about five months of full-time work. As the MPGS students are not personnel attached to the centre, it can be assumed that there will be limitations to their handling of health documentation and cases. They are expected to rotate through a single unit under the personal supervision of a single psychologist (who may not be a specialist). The theoretical training, which corresponds to most of the credits, is taught by university professors and associate professors.

Therefore, it is easy to see that the specialist training (via the PIR) allows a level of depth in the different fields of activity of the clinical psychologist and therefore a degree

of professional training that is clearly superior to and more complete than that of the MPGS.

Although some postgraduate lecturers argue that the MPGS as specialised training should be at the same level as the PIR (Carrobbles, 2012; López Méndez & Costa Cabanillas, 2013), the fact is that, in addition to the differences mentioned above, this contrasts with the same European configuration to which they are appealing. They do so, equating the PGS to the European Certificate of Psychology, or the EuroPsy. The EuroPsy was created by the European Federation of Psychologists' Associations (EFPA), mainly to establish a benchmark of quality for education and practice in psychology, and to facilitate the mobility of psychologists among European countries. This certification means that the psychologist has completed an academic curriculum in psychology of at least 5 years (300 European credits) and can demonstrate at least one year of full-time supervised professional practice. This is a minimum requirement for this certification which does not have a specialist character but rather denotes a generalist level of preparation (Santolaya Ochando, 2012). To be considered a specialist requires additional training and practice, which the EFPA has not yet established for Clinical Psychology. Although the MPGS does not reach a year of full time supervised practice, it can be understood that it meets the minimum requirements for work in the field of (mental) health, which is not equivalent to being a specialist in that field. In this regard it is worth noting that, in the late 80s, the committee of experts commissioned by the COP to prepare a technical report to determine the basis of the training of specialist psychologists through the PIR stated that "the time required for adequate postgraduate training in which the resident has sufficient periods to rotate through the various care units will be between three and four years" (Colegio Oficial de Psicólogos, Psychological Association, 1990, p. 61). Now some postgraduate lecturers justify maintaining the university postgraduate training detached from the PIR on the basis that nine and a half years is a "disproportionate" duration for the training of a clinical psychologist (Carrobbles, 2012; López Méndez & Costa Cabanillas, 2013). However, at a time when the bachelor's degree had a duration of five years in most university curricula, it was deemed appropriate to make it up to nine years of education in this consensus report. Incidentally, I note that Professor José Antonio Carrobbles is among the members of the committee that drafted the aforementioned report.



THE BACHELOR’S-MASTER’S-PIR ITINERARY, A LOGICAL ORDER

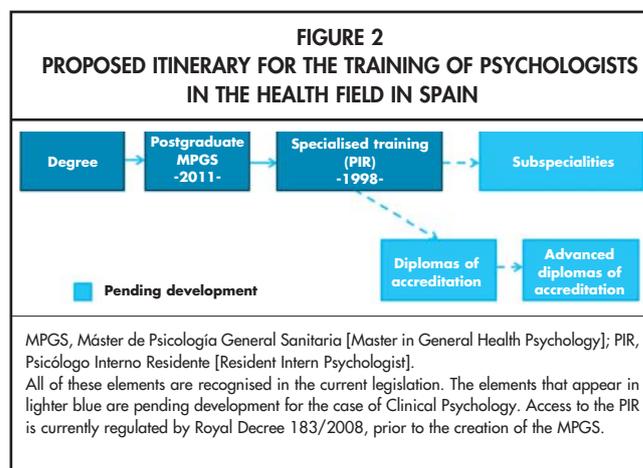
The fact that the speciality was created first and subsequently the figure of the generalist, in the health field, has meant that access to the specialised training is determined by a Royal Decree of 2008 (Royal Decree 183/2008 of 8 February, which determines and classifies the specialities in Health Sciences [BOE, no. 45 of February 21, 2008]) which predates the creation of the MPGS (2011). To correct this requires a change in the regulations which, despite having been announced by the competent authorities on several occasions⁵, has not come to fruition.

In recent years, the main associations in the field (including the ANPIR), the General Council of Psychology and the National Commission of the Speciality of Clinical Psychology (the advisory body to the Ministry of Health for matters related to the speciality)⁶ have produced various writings defending the need to reorganise the curriculum itinerary of the clinical psychologist in accordance with the new configuration of university studies in this field, and particularly after the creation of the new generalist healthcare profession for psychologists.

Without wishing to dwell on the details of the argument, it defends that, if a master’s degree has been created with specific health content because the bachelor’s degree in psychology, of a multifunctional nature, does not provide sufficient training to practise in the field of health, this generalist university training should be required of psychologists prior to commencing the specialist training to ensure that it is part of the curriculum of the future clinical psychologist. The PIR training does not replace the university education, but rather complements it in order to qualify as a specialist. Figure 2 shows the outline of the proposed phased training itinerary, which does not end with the recognition of the speciality. In addition to the elements already created, it is to be expected that there shall be added, according to the rules already in force

(Law 44/2003 of 21 November, regulating the health professions [BOE, no. 280 of 22 November 2003]), future subspecialities (formally called Areas of Specific Training) or new specialities from a common core with the speciality of Clinical Psychology. Child and adolescent clinical psychology, clinical neuropsychology and health psychology are the fields of (sub) specialisation most often mentioned. Other elements within the training itinerary of healthcare specialists, subsequent to the residence, are the Accreditation Diplomas (and Advanced Accreditation Diplomas). These official diplomas will be accepted by the public administration to certify the level of education attained by a professional in a specific functional area (say, psycho-oncology) in a particular speciality, according to the activities of accredited continuing education carried out by the candidate in the corresponding functional area. The whole of this long journey is consistent with the idea that the training of healthcare professionals does not end at university, or even with the qualification of specialist, and that in the field of health it is particularly necessary to encourage, accredit and permit its identification by society.

The training should be cumulative and sequenced. Only if the prior level of preparation has been successfully acquired, with the relevant knowledge and skills, can the



⁵ In October 2011, the Director General of Professional Regulation, of the Ministry of Health, Francisco Valero Bonilla, announced in writing his commitment to initiate proceedings for the modification of Royal Decree 183/2008, in order to establish possession of the MPGS as a requirement for access to the specialised healthcare training in clinical psychology. However with the change of government a few weeks later, the initiative was unauthorised. In March 2012, the new government, in response to Ana Oramas González-Moro, a congresswoman of the Canary Coalition, wrote that it planned to amend the aforementioned Royal Decree “in order to address, among other things, the requirements for access to the specialist training in Clinical Psychology”. The amendment was postponed while the general conditions and requirements for obtaining the MPGS were not formally approved, which occurred in June 2013.

⁶ The position of the Conference of Deans of the Faculties of Psychology regarding the Bachelor’s-Master’s-PIR itinerary has been more uncertain, ranging from lukewarm support to indifference.



further level of preparation be accessed. In fact, the aforementioned Royal Decree which currently regulates access to the PIR, establishes for the other clinical care specialities the requirement to be "in possession of an official university degree which qualifies the candidate to practise the profession in Spain". However, in the case of psychology, instead of demanding that the candidate is qualified to practise in the health field, the wording of the corresponding article requires "possession of the official university bachelor's degree in the field of psychology or the (old) undergraduate degree in psychology".

Despite the consensus reached in the profession, it is worth responding to the main arguments against the proposed phased itinerary. Firstly, it has been said that incorporating the MPGS into the curriculum of the future clinical psychologist would make the training disproportionately long. As I have demonstrated above, in the initial design of the specialist training as a clinical psychologist, a PIR period of three or four years was deemed appropriate, after a degree in five years. The duration of the proposed itinerary is 9 and a half years, somewhat less than the duration of the internships of all of the specialities with responsibilities for direct patient care (i.e., the clinical specialities), which is about 10 or 11 years. It would be intriguing to know why there are psychologists who argue that the clinical psychologist requires less preparation than other clinicians, including psychiatrists, with whom we share service. But the argument of the years of duration diverts attention from the crux of all this: the deterioration of the university training of the future clinical psychologist. It should be understood that in order to access the master's degree the candidate is required to have completed, during the new bachelor's degree, 90 credits specifically in healthcare. This is not required in the curriculum of the future specialist. Consequently, for example, a student who, during his or her undergraduate degree, has chosen an itinerary linked to social or educational psychology could not access the healthcare training as a generalist (i.e., the MPGS), but he or she could however access it as a specialist (i.e., the PIR). Therefore it is not only about the duration but that the time involved also has the appropriate characteristics for the professional profile.

Another of the arguments put forward is that no other speciality requires the level of a master's degree to access the specialist training. This is also not true. Medicine, which is the main benchmark for the resident-intern model is one of the few university courses that has maintained

the six year duration following the implementation of the Bologna Process in Spanish universities. According to Royal Decree 96/2014 of 14 February, amending Royal Decrees 1027/2011, of July 15, approving the Spanish Framework of Qualifications for Higher Education (BOE, no. 55, on March 5, 2014), the new bachelor's degree courses of at least 300 credits may be recognised as master's level, i.e., a double degree would be obtained. This is the case of Medicine and other qualifications in the field of Health Sciences, such as the new bachelor's degree of five years in Pharmacy.

It has also been argued against the Bachelor's-Master's-PIR phased itinerary that the exam for access to the PIR certifies that the applicant has the necessary knowledge. This reasoning can lead us to conclude that it is not necessary to study psychology to train as a specialist in clinical psychology (other studies could suffice or even no studies, as long as the applicant passes the entrance examination to access the PIR). This also means assuming that the teaching imparted in private academies for exam preparation, usually by younger residents, is comparable to accredited university teaching. Needless to say, the university lecturers that are against the proposed itinerary have avoided resorting to this argument.

Finally, it has been argued against requiring the master's, as a way of ensuring an education "that does not depend on the economic capacity of the student" (Colectivo de Estudiantes de Psicología, Psychology Student Union, 2013). This argument is bizarre because it comes from the same group that mobilised to create the compulsory master's degree for all students interested in practising in the field of health (Colectivo de Estudiantes de Psicología, Psychology Student Union, 2010). In practice, of the approximately 5,000 clinically-oriented graduates who we can assume leave the psychology faculties each year, only those who access the paid training of the PIR system (approximately 125 at present) are exempt from previously completing the master's degree. This can hardly be sustained as a serious defence of the public sector. On the one hand, exam preparation for access to the PIR, which is extremely competitive, is in the hands of private academies that are unconnected to public aid. On the other hand, as mentioned before, access from the new bachelor's degree, which is neither healthcare-based nor professionalising, actually diminishes the preparation of clinical psychologist, the qualification required by law for working in the SNS and public-private centres.



THE DAMAGE TO THE PROFESSION

Thus far we have placed the emphasis on the need to incorporate into the curricula of specialist psychologists the specifically healthcare content taught in the psychology faculties so as not to impoverish their curricula or training, however there are other less direct but equally important consequences. The new arrangement of the profession in this field should facilitate the coexistence of the two figures (generalist and specialist) without confusion or conflict. The PIR places are limited, and the places for clinical psychologists are too. However, it is easy to imagine that at the universities there will be little or no interest in increasing the PIR spaces as a natural and realistic professional opening for the students of the generalist master's degree while the two courses are offered in parallel and with competence profiles that are so precariously defined. What is to be expected is a dispute over the fields of activity to the detriment of our professional organisation and cohesion.

It is easy to see that those who argue against the itinerary do so while also arguing that the two training paths are different ways of achieving the same professional effects or perhaps greater ones in the case of the university route (Carrobbles, 2012; López Méndez & Costa Cabanillas, 2013). Apart from the problems for the profession of having two conflicting professionals, what would it mean if the figures of generalist and specialist were equivalent? If extending the university education of the psychologist by one and a half years has the same professional effect as a costly four-year specialised training program, what administration would promote or maintain the latter? And if the PIR ceased to exist, where would the profession of clinical psychologist be in the SNS? For a start, we would have a psychologist with fewer years of training than the nursing professionals specialised in mental health (six years) and a long way from the years needed to be a psychiatrist (ten years).

Critics of the phased itinerary wanted to make people believe that the incorporation of the PGS to the SNS would serve to prevent the "intrusion" of the other healthcare professionals, namely primary care physicians and nurses. I do not know how the inclusion of a professional profile that would accumulate fewer years of training than that of nurses could help contain, in an increasingly interdisciplinary environment, the use of psychological interventions by other professionals.

The issue of the number of years of training may seem trivial, but it is what has determined to date issues such as

remuneration, occupational categories and professional development. The differences between the old diplomas and undergraduate degrees are perpetuated throughout professional life in all aspects, not just salary. As I am writing this I learned that in Catalonia the new agreement being negotiated by the XHUP (Xarxa Hospitalària d'Utilització Pública, in Catalán; Hospital Network for Public Use, in English) represents a downgrading for clinical psychologists. According to the latest proposal, clinical psychologists are located in the subgroup C1, while medical and pharmaceutical specialists (remember: both professionals have a recognised double bachelor's and master's degree) would form part of the subgroup A1, previously shared with clinical psychologists. This has direct consequences on the remuneration in the contracts of psychological specialists, but it is easy to imagine that belonging to a lower subgroup will also have effects on the development of skills and general consideration within and outside of the healthcare system.

Among other things, our ability to influence the organisations where our care functions are determined or where the resources dedicated to mental health are decided depends on our location in the system. If we wish to increase the capacity for self-management of the clinical psychologists in the SNS, surpassing the current structures, which are reminiscent of a time before our recognition as a healthcare speciality, it is imperative that we have the same status as other practitioners, in particular those with whom we share service.

The proposed itinerary is also an opportunity to establish a formal link between the faculties and the hospitals, an ambition that has mutual benefits for lecturers and clinicians. The same benefits would be of value to applied research. Access to epidemiologically representative clinical populations, for some, and the possibility of carrying out research with a predominantly psychological orientation, for others, are clear advantages of the desired collaboration.

Finally, it should be made known that access to the PIR in the current situation is a dead end street for the 97% of psychologists who, motivated to access the specialised training, do not obtain a place. The graduates who do not meet the minimum qualification requirements in this field, set at the master's degree, cannot practice as generalists. The false expectation that the PIR is a real alternative for those who cannot access the professionalising master's degree, would serve, however, to leave intact one of the great problems of studies in psychology: its massification.



CONCLUSIONS

If we assume that psychology has a transcendental role in the health field, we need to establish some minimum requirements, to the extent that it is possible, to ensure that the work is carried out with sufficient preparation. That is what the legal regulation of a profession or speciality involves: it requires accreditation of a certain level of training/experience for what could previously be done without it. Within the diverse European panorama, most countries have implemented ways to regulate the work of psychologists in this field. But, by definition, the speciality should require more than the basic training to practise in a particular field. The PIR system is a milestone in the consolidation of (clinical) psychology in Spain. Although there is room for improvement in its development, four years of exclusive paid training, under the supervision of different specialist psychologists in the benchmark environment for the provision of healthcare services in the country is the best plan to which psychologists can aspire anywhere. However, as we have said elsewhere (González-Blanch, 2009), the PIR is not the maximum training, rather it is the minimum requirement to be a clinical psychologist.

The creation of the MPGS represents a clear advancement for applied psychology in Spain. It solves the need to improve the university training of psychologists who wish to work in the direct care of people's (mental) health. This structural change in university education should benefit the training of all psychologists in this field, particularly the future specialists. On this point our profession has reached an unprecedented consensus.

It is wrong to suggest that the impoverishment of the university training of the specialist improves the employment scenario of the generalist. This ploy can only serve to divert attention from the more obvious motive, i.e., the difficulties psychologists have in finding employment: the hypertrophy of academic psychology and, consequently, the disproportionate number of psychologists that are trained in this field. The clinical psychologist is the prime example of the category of psychologist; it is for the students and it is for society in general. And the SNS is where the health professions have the most visibility for the citizens of Spain. If the employment status of the clinical psychologist, guaranteed by their training, is weakened in the SNS, the entire profession is disadvantaged, not just the specialist.

The clinical psychologist, as a psychologist from the branch of (mental) health, pre-exists as a social reality to its legal establishment. Similarly, the way in which academic and political authorities proceed to implement and regulate the training that corresponds to this professional ends up determining the image of the clinical psychologist on the part of the users, professionals, managers and, ultimately, society.

Academic and professional psychology should strive for an organisation that, avoiding intraprofessional confusion and conflict, reaches the necessary union to promote the expansion of quality psychological care in the healthcare system, both public and private, without weakening what has already been established.

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