PSYCHOLOGISATION PROCESSES VIEWED FROM THE PERSPECTIVE OF THE REGULATION OF HEALTHCARE PROFESSIONS IN SPAIN

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Abstract

This study follows on from others based on a genealogical perspective of psychologisation processes and mechanisms (Varela, 1997; Álvarez-Uría, 2005; Gordo, 2006; Parra, 2007; Álvarez-Uría et al. 2008; Álvarez-Uría and Varela, 2009). Our analysis focuses on the impact of the current legal transformations taking place in Spain in public health professions. Firstly, we briefly outline an analysis of the discursive structure of the Spanish social psychology of conflict, as this will help us to describe our understanding of the concept of "psychologisation". The link between both topics will allow us to illustrate the new discipline and legal inflections of those processes.

Key words: Ley de Ordenación de las Profesiones Sanitarias (LOPS) [Healthcare Professions Act], social psychology, psychologisation

Psychologisation: discipline and legal aspects

The so-called Ley de Ordenación de las Profesiones Sanitarias (LOPS) "Healthcare Professions Act" (hereafter LOPS) is an act which was passed in Spain in 2003, and which has regulated professionals in this field, and the activities of healthcare training centres thereafter. The act's importance lies in the strong opposition it fuelled among Spanish psychology practitioners and academics, whose demands are also an important aspect of our analysis to elucidate psychologisation processes in operation. Prior to this analysis, however, we will operationally define our understanding of "psychologisation", which derives, by in large, from a previous study we conducted on the discursive structure of the social psychology of conflict in the Spanish state. For the purposes of this study, citing Parker (2008, p. 74), we understood that we "might assume that those on the more <social> side of the [psychological] discipline would be more sympathetic to social explanations". And in the same way as he did, we saw that "this is not the case".

We identified dynamics that significantly reduced conflicts to mental (and emotional) processes, which individuals use to interpret them. Therefore, conflict was constantly moving towards spaces considered 'psychic' (chiefly perceptive, cognitive and/or communicative), which does not necessarily imply that they are only personal or individual. The insidious side of the psychosocial approach to conflict makes excessive use of replacing certain social problems by the way in which we subjectively internalise or understand them. Material demands expressed in certain social actions can, thus, be redefined as mere psychosocial 'vulnerabilities', and, at the same time, social conflicts themselves are analysed on the basis of interpretative mistakes or communicative deficiencies among the parties. Therefore, the uneasiness that leads to conflict might not be derived from a physically prompted situation (job insecurity, disciplinary measures, low wages, excessively long working hours, etc.) but subjectively created or felt. Consequently, we come across phrases such as: "complaints are *badly tolerated* working conditions" (Munduate and Martínez, 1998, p. 45) regarding the analysis of conflicts at an organisational level. Or, the usual reference in the discipline to the famous UNESCO phrase: "since war begins in the minds of men, it is in the minds of men that the defences of peace must be constructed" (e.g.: Alzate, 1998, p. 78). This phrase provides us with a perfectly clear image of the scope aspired to by the majority of the social psychology of conflicts.

By turning 'psychic' aspects into the privileged space of causality, development and/or elimination of conflicts, social psychology prevents individuals from understanding the historical and political positioning of their own actions. Psychologisation, therefore, is the increasingly widespread recourse to individuals' own internal entity to offer explanations and guide actions in a wide variety of social situations; studying it is thus highly relevant for understanding our social reality. This recourse cannot be viewed as neutral, since it

expands, as required, at the expense of the fragmentation of our social relationships and understanding of the material elements influencing our behaviour. In this respect, it is also important to emphasize the connections between disciplinary discourse and the social or political reality in which it originates or is applied. In our case, the former were legal changes that fully affected the field of psychological practice.

From the discipline-discursive field to the professional field of psychologisation: healthcare psychology

By investigating professional psychology operating within the field of healthcare, we are able enable to observe psychologisation mechanisms in the strategic framework of psychological discipline and legislation.

As we shall demonstrate in due course, the LOPS— which was passed in Spain in 2003— suggests new forms of psychologisation in healthcare and the therapeutic side of discipline. Moreover, its interest lies, not only within the 'psychosocial' subfield, but also within the social "conflict" accompanying this legal transformation in the general field of psychology, prompting a large number of demonstrations and protests by professionals, lecturers, and university students. This 'uneasiness' in the discipline of Spanish psychology was the most intense since the 1980's, when the 'Psychiatric Reform' (BOE –Official Gazette of the Spanish State-, 1986) was passed.

The question about whether psychology is a healthcare profession or not, and whether university psychology courses are healthcare training, reopens the old debate which makes it difficult to insert psychological perspectives into the biological and social community sphere.

The reality of the institutional 'healthcare' field of psychology fluctuates, from a historical point of view, in the difficult space between the biomedical and psychiatric concept of illness, and a more 'sociological' approach, which had been demanded back in the 1960s and 1970s, particularly due to the establishment of anti-psychiatry (Álvarez-Uría, 1983; Álvarez-Uría *et al*, 2008).

We are, thus, dealing with current legal transformations of the regulation of professionals and healthcare training centres, with a historical logic that takes us back to the time of the 'Healthcare Reform' (1986), and the fierce debates regarding the broad understanding of the aetiology of mental health and mental illness that took place in the preceding decades (Desviat, 1994).

An important debate at that time centred on the need to view mental illness from a more social community perspective, and professional conduct as a result. This implied carrying out a fundamental transformation in psychological institutions, shifting attention

from mental hospitals, and, above all, from psychiatric intervention to frameworks which inserted therapy within the community (understood as social, local or sectoral). This was an especially important moment because psychopharmacology was also beginning to be an extremely 'effective' tool in the treatment of mental illness. All these issues shared a common political background: the transition from General Franco's dictatorship to a democracy. Consequently, the 'Healthcare Reform' coincided with the years when PSOE (the Spanish Socialist Workers' Party) was in power— 1986 being the year when the party won the elections for the second time running. By this time, the party had also united the vast majority of the Spanish socialist movement, consolidated its abandonment of Marxist theories, and shifted towards a social democratic ideology. Finally, this was also the year when Spain signed the Treaty of Accession and joined the EEC.

Various strikes and demonstrations by mental health professionals (many of whom had joined either the Communist Party or PSOE) demanded the communitarisation of psychiatric care, as a necessary mechanism for state social improvements to be put into practice in this field. But the delay in the process merely highlighted the supposedly progressive tendency of the left party in power. Given this situation, we can also question the extent to which this 'Healthcare Reform', implemented in the *Ley General de Salud* (General Health Act) in 1986, was in fact a legal change that responded to communitarisation demands, or whether it was a break away from effective community mental health treatment dynamics, which had in actual fact been developing during the years prior to it (García, 1995; González Duro, 1987).

This historical overview will help us to properly contextualise the main elements of our analyses, regarding, both, the current situation, and the conclusions we have reached.

A case study: the LOPS

The 44/2003 LOPS (Healthcare Professions Act) (BOE, 2003a), which came into effect on 23 November 2003, and Royal Decree 1227/2003, of 10 December the same year (BOE, 2003b), transformed the legal regulation and authorisation of the various professional fields, and Spanish state and private healthcare centres and services. The LOPS was a direct response to a "situation with virtually no regulations" (BOE, 2003a, p. 41443), which seems to have been the result of the 14/1986 'General Health Act' (BOE, 1986) insofar as it took as its main reference the free practice of healthcare professions, but not their regulation. Concomitantly, it also concerned adaption to the legal framework of the European Community, due to the directives on reciprocal validation among Member States of the European Union of diplomas, certificates, and other degrees for the practice of healthcare professions. Similarly, professional healthcare practice was legally re-

stricted, since the activity conditions were also regulated, and the functional aspects of the various healthcare professions were established, for which they tried to guarantee specific professional training.

Article 2 of the LOPS states two criteria to determine which professions are recognised as healthcare professions (BOE, 2003a, p.41444):

1. Those professions which university regulations recognise as degrees in the health field.
2. Those professions which have an association recognised by the authorities.

According to the first criterion, the following are directly recognised as healthcare professionals: those in possession of a degree in Medicine, Pharmacy, Dentistry and Veterinary Medicine; those with a diploma in Physiotherapy, Nursing or Speech Therapy, among others; as well as those with vocational training qualifications in a wide variety of areas, such as Dietetics, Laboratory Clinical Diagnosis, Radiotherapy, etc. Similarly, article 6.3 also recognises those in possession of an "Official Title of Specialist in Health Sciences" as healthcare professionals at a degree level— an area mainly reserved for psychologists, chemists, biologists and biochemists.

Here is where the main conflict generated by the LOPS in relation to psychology lies. Placing a university degree in psychology within the 'Social and Legal Sciences' category, instead of classifying it as 'Health Sciences', means that psychology graduates are not directly recognised as healthcare professionals. They, therefore, made a justified request for a psychology degree to be moved to the Health Sciences category: a 'simple' administrative change that became a central issue given the key role of this classification in the very definition of 'healthcare profession' offered by the LOPS. Otherwise, these graduates would only be recognised as healthcare professionals and be able to practice as such by being in possession of the 'Official Qualification of Psychologist Specialised in Clinical Psychology'. As a result, not only did future psychologists see their possibilities of practising within the healthcare domain reduced, but, in addition, a large number of them, who were already working in this field without any problems, were now thrown into a precarious situation of legal uncertainty.

On the other hand, the LOPS only provided one way to train specialists (in this case, 'clinical psychology' specialists), which "will take place out by means of the residency system in authorised centres" (BOE, 2003a, p. 41449). 'Clinical psychologist' training was, therefore, established by only one legally accepted way: 'Resident Intern Psychologist' training (known as PIR in Spanish). Psychologists (professionals, lecturers, and students) based their demands on the scant number of PIR posts available, and their awareness of the consequences this would have. For example, in 2005, there were 81 vacancies for approximately two thousand candidates (COP, 2005b). This situation was further

complicated by the fact that psychology, as a university degree, had grown tremendously, in terms of the number of both graduate and undergraduate students, since the 1980s. In addition, a large percentage of them— around 65% (Chacón, 2004) — were interested in the specific healthcare training field.

Furthermore, there was the issue of psychology graduates who were already working as professionals in various institutions, whether they provided healthcare or not. Their legal situation was very delicate in view of the centre regulations derived from Royal Decree 1277/2003: if they did not qualify as healthcare professionals, they could even be expelled from Healthcare Centres. A recognition process was implemented for professionals who were already working, and although it did take into account the number of years the professionals had been practising— or their PIR training, or similar—it was criticised for being too slow and excessively restrictive. However, this specialist recognition process emerged as a result of the creation of the 'Official Qualification of Psychologist Specialised in Clinical Psychology' in Royal Decree 2490/1998 (BOE, 1998), and its successive legal modifications, such as Ministerial Order 1107/2002 (BOE, 2002) and Royal Decree 654/2005 (BOE, 2005).

It is important to briefly clarify a couple of issues with regard to the PIR training system. This mechanism was created to allow psychologists regulatory access to providing healthcare in healthcare centres, and it borrowed its main guidelines from the existing systems for doctors, chemists, and biologists (known as MIR, FIR and BIR in Spanish). The first national official PIR vacancies announcement took place in 1993. Royal Decree 2490/1998 (BOE, 1998) was finally passed in 1998, creating the 'Official Qualification of Psychologist Specialised in Clinical Psychology', with PIR becoming the necessary training course to obtain it. The Royal Decree was consolidated in 2002, after the Supreme Court rejected the appeal presented by the Spanish Psychiatry Society, the Spanish Biological Psychiatry Society, the Spanish Legal Psychiatry Society, and the Medical Association General Council. The associations that signed the appeal demonstrate how strong the sense of unity was behind these legal processes. As we will see below, the conflict surrounding the LOPS will better demonstrate this corporate clash.

The psychology sector generally agrees (e.g. González-Blanch, 2009; ANPIR, 2008) that Royal Decree 2490/1998 is one of its most important legal achievements, since it responded to the demands that had started several decades previously, and finally provided the legal integration of psychologists into the National Healthcare System. Both, at that time, and today, the 'Official Qualification of Psychologist Specialised in Clinical Psychology' was/is acclaimed as the gateway for psychologists into the National Healthcare System. However, in the light of the LOPS, it now seems to have become the only narrow concession to have been made to psychology.

As an extensive array of articles and statements document, the years following the LOPS becoming effective were marked by a real social and political conflict of dimen-

sions hitherto never seen within the field of psychology. Similarly, there is a strong accord towards emphasising the eminently critical and fundamental nature of the moment the profession was going through (Santolaya, 2004).

Dissenting voices towards the LOPS began to be raised immediately after the passing of the Act in December 2003; however the general elections on 14 March 2004 delayed the generalised protest of professionals, lecturers, and students, since PSOE—the opposition party at the time, which subsequently went on to win the elections and oust the Partido Popular from power— had promised to modify this Act, which prompted an impasse which would not be settled until November 2004, when everybody thought the promise had been forgotten. It was only then that psychology really started to progress. *Ad hoc* associations (especially 'Group for Psychology and Health') were organised, the student movement sprang into action at various faculties around the country (information talks, manifestos, sit-ins, etc.), autonomous community and state Official Psychology Associations coordinated communiqués, whilst Deans from Psychology Faculties expressed their disagreement in different ways: official communiqués, press releases, specialised journals, etc. Ultimately, these movements culminated in a mass demonstration— around 15,000 people, according to the organisers— on 18 December that same year, which brought together professionals, students, lecturers, and citizens from all over the country.

The current state of psychologisation and its "legalities"

The LOPS is not an isolated event, nor even qualitatively differentiated from the process of legal recognition that has been on-going since the 1970s; psychologists' current demands are very similar to those of the past, and they underline the importance of professional integration into the state healthcare system (Duro, 2004). In fact, the attempt in 1978 to create Clinical Psychology Schools for doctors dependent on the Psychiatry Department of Medicine Faculties (in Salamanca and Valladolid) and on the Clinical Hospital in Madrid, or the aforementioned Supreme Court appeal regarding Royal Decree 2490/1998 made by some psychiatric and medical associations, are part of the same resistance against the professional expansion of psychologists into the health domain.

In this respect, the LOPS' consequences for this particular professional sector did not have to be as catastrophic as psychologists led us to believe. Psychology has developed, and increased, its significance within healthcare since the 1970s, despite lacking important legal recognition. Some even believe that this lack of 'healthcare professional' recognition would not prevent psychologists from carrying out their present practice in healthcare centres (Duro and Martínez, 2004). As far as we are concerned, strong corporatism (psychia-

tric and medical against psychological) defending their own professional corner lies behind all these legal clashes.

However, perhaps the most relevant issues here are the historical transformations of psychologists' discourse of demands, and how they make use of the old debate on the notion of 'health'. Equally important in this regard, is the understanding of the relationship of these variations with the changes that are now taking place at Spanish universities, due to the adaptation to the EHEA (European Higher Education Area).

A key confusion, —which is not groundless— in the LOPS text, has to do with the superposition of 'healthcare' and 'clinic'. It is a recurrent matter in psychologists' demands that this law insists on a bio-medical concept of health instead of a comprehensive bio-psycho-social one. It refers to the traditional WHO definition of 'health', which is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (quoted, among others, in Fernández, 2004, p. 14).

This issue leads us to important differences between the current discourse of psychological protest and 1970 demands, which stressed, among other things, the inclusion of psychology in primary healthcare, and also the differentiation of hospital services when treating mental health. At the same time, these demands derived from a concept of mental health marked by highly comprehensive community-based perspectives, which understood that clinical practice was only one of the many possible ways for psychology to intervene in health. Today, this community-based trend has all but been forgotten, and the political and institutional criticism many participated in has completely disappeared. Although psychologists do still criticise the biomedical model, which is undoubtedly defended by the LOPS, their discourse has now suffered a significant rift, which, paradoxically, was prompted by the fact that the discipline is now more like that model. This is evident, if we take the situation of the clinical psychologists who have gone through the PIR training as an example, and can be espied in the discourse of their most important association: ANPIR (National Association of Resident Intern Psychologists). This group stands in favour of the LOPS, because they believe that this act has emphasised the importance of rigorous training in the way psychology acts within healthcare. They also consider, as do many others— mainly clinical psychologists— that having a psychology degree is not sufficient training for the field of healthcare. For them, the main problem is the scant number of PIR places offered.

The basic issue is not the number of places, but rather having the PIR as the only available mechanism, because it clearly integrates psychologists within the prevailing biologicist model, since practical PIR training is carried out in hospitals and is heavily psychiatric. Having said this, the coming into effect of the 'Official Qualification of Psychologist Specialised in Clinical Psychology could have been not only a considerable milestone in psychology's historical demands, but also its obligatory link with the biological and medical perspective of mental health (Duro & Martínez, 2004). Moreover, the consequences of the

LOPS could likewise increase such adhesion by regulating the private sector as well as the state healthcare system.

This central transformation of psychologists' demands is even more evident when analysing those put forward by Psychology Faculty students, since their main demands are not as linked to the need to reintroduce 'community-based' and 'sociologizing' healthcare advances. Neither do they bring up the necessary debate about the demedicalised concept of mental health; instead, they try to defend their proper clinical training and right to diagnose, treat or even prescribe medicines (Berdullas *et al*, 2005; Muse, 2007; Parker, 2007). Consequently, we should seriously question the *political* nature of this movement, which was obvious in the actions and demands for transformation in the years preceding the 'Reform', since their demands mainly concern the logic of corporate and technical-professional sectors.

University education is especially relevant in this scenario, principally because, as mentioned above, academic syllabuses are now undergoing profound changes since they are being adapted to the EHEA in the 'Bologna Process'. This process, begun in 1999 after European Education Ministers signed an agreement to promote a process of convergence among European university degrees, will, among other advantages, make the exchange of graduates easier. In this new context of university reform, moving psychology degrees from the 'Social and Legal Sciences' classification to the 'Health Sciences' category, is, perhaps, the main demand of those psychologists who understand that a degree in psychology is in fact healthcare training. However, this change, which, given the criteria provided by the LOPS, seemed to be enough to recognise psychologists as healthcare professionals, is not just an administrative change, as some may believe or champion. This change carries with it the demand to adapt psychology syllabuses to a 'healthcare' reality, which again is confused with the 'clinical' sector.

A significant number of clinical psychologists have called for the subjects in the syllabuses to be predominately 'healthcare-clinical', since the obvious disparity of training they offer (psychology of education, social psychology, human resources, etc.) is an argument wielded by the Government itself for not recognising a psychology degree as a 'healthcare' qualification (COP, 2005a). Consequently, the 'achievement' of including the psychology degree within Health Sciences— replete with all the evident advantages this would entail for the professional healthcare practice of psychologists— becomes the perfect excuse to permanently remove the more socio-critical subjects, or those which are not in line with established clinical rules, from the faculties. This is already happening, and the difficulty social or educational psychologists, for example, face in making themselves heard in the main forums of debate on the LOPS is obvious. Moving psychology from its 'Social Sciences' domain to the 'Health Sciences' category, does not just mean turning psychology into a "healthcare" discipline, but also deleting the awareness of the clear social basis of health.

At present, an intermediate route is being negotiated by attempting to recognise a 'Master's Degree in Clinical Psychology", offered in Psychology Faculties, as healthcare training, rather than the degree as a whole. This would, of course, solve the problems of the availability of professional posts for psychologists— derived from the very strict criteria for professional recognition for them— as they would not solely depend on successfully passing the PIR. Furthermore, the hospital-psychiatric 'bottleneck' of this system might be avoided. Nevertheless, it seems clear that it would have absolutely no bearing on the clinical perspective of healthcare. Although it does not prioritise psychiatric training, at least it facilitates highly cognitive-behavioural training, which is the prevailing perspective in Spain. Community and social perspectives are still not included, and neither are other training processes— even clinical ones— which had been supplanted by the university cognitive-behavioural bias. This is the case with psychoanalytic training, which has demonstrated its healthcare capacities, and has been in great social demand all along, regardless of other types of criticism it may receive.

As a result of the above, the LOPS should be understood, in its apparent contradiction, as a manifestation of both the increase and loss of power within psychology. On the one hand, social mobilization allows us to understand the legal process as a reinforcement of medical and psychiatric power in the healthcare domain against the interests of psychology. Nevertheless, the predominant psychologist perspective, after the different alterations it has undergone since the LOPS (Master's Degree, the turning of psychology into a healthcare degree taking advantage of the syllabus changes due to the "Bologna Process", legal regulation of private professional centres, etc.) has reinforced its position as a complement to the medical model, rather than as a real alternative to it. We must not forget that the second criterion for legal healthcare recognition was conditioned by the existence of a professional association recognised by the authorities— an issue without any apparent problems for most psychologists who have a say in the main specialised organisations and media. The aim is to rid the discipline of the various alternative therapeutic options that have arisen in its own field, and which are not involved in the fight for 'scientific' recognition and, hence, do not compete for access to the public professional domain. The importance of this matter shows that this problem is not exclusive to Spain, since it can also be found in other European countries, such as England (Parker, 2008). The English case shows us that disagreements concerning certain categories (in the case of Spain, the 'healthcare' issue; in the case of England, the dispute regarding the social and professional recognition of 'counselling', 'psychologist', and 'psychotherapist) are more than just a titular issue. The recognition that supposedly lay in proven 'scientificity', in some versions of psychological care, was actually finally decided by the state legal recognition of the possibility of professionals publicly offering their services with these labels, so they would have legal and tax protection for their activities.

Conclusion

As we have seen, in social psychological discourses concerning the beginning and resolution of conflicts, the socio-political background disappears. Or, at the very least, it can be left out, as it is the subject of study of other social science disciplines. Consequently, the interest mainly lies in psychic mechanisms through which conflict becomes a matter of perceptions and communications that are rationally mistaken or generate social confrontation.

Nevertheless, we have also seen that the demands of the conflict prompted by the coming into effect of the LOPS, were based on corporate rather than on socio-political questions. Or, phrased otherwise, these demands do not raise the importance of either the debate about the socio-political basis of mental health, or the modification of the institutions or social organisations which could eradicate it. Instead, they prefer to defend the scientific nature of the healthcare — preferably clinical— methods psychology uses, as well as how they adapt to, and are required by, the healthcare domain.

If social psychology no longer needs to refer to the socio-political basis on which conflicts are sustained, could we conceive of a healthcare psychology which asserts the community as the mental conflict resolution ground?

Social psychology will settle conflicts in a psychic space, the *management* place for the way reality affects subjects. Nevertheless, healthcare psychology only sees that space in a tangential manner, since it deals directly with those problems posed by biologicist viewpoints. The terms of the conflict are settled according to the accepted basis of an organicist positivism which, in the light of the 1970 institutional struggles, seemed to have been overcome, or at least critically problematised.

The coming into effect of the LOPS should then be understood in terms of a rebiologisation, which had apparently been overcome, but which, in actual fact, clearly not only affects the medical field, but also psychology and other cultural, and even scientific, fields. Other current transformations in the field of psychology are a good example, such as the proposal to implement the AOTP (Assisted Outpatient Treatment Program) which focuses its healthcare practice on the logic of pharmacologization, and which runs the high risk of the juridification of diagnosis decisions about the mentally ill (Sánchez, 2006). The neurological foundation of the new orientations within social scientific discourse (flux theories, network theories, etc.) could be understood in the same way. If psychologisation is not sufficient to neutralise its social, political and economic principles with action and social reflexivity, then biologisation will, once more, eliminate every trace of them. Understanding today the meaning and social depth attained by the psychologisation process—which has been going on for over a century— implies dealing with the ex-

tent, and specific repercussions, of the perspectives and biologicist mechanisms which are unavoidably related to it.

Furthermore, since the time of the Spanish transition to democracy, psychology has seen its social power increase on a massive scale (Fernández, 2006). Indeed, the number of graduate and undergraduate psychology students has risen spectacularly (González-Blanch, 2004), at the same time as psychology has gained access to an endless number of new professional roles within the fields of business, sport, politics, education, and law. The specific elements of its theoretical analyses have been successfully applied in the field of social sciences. Likewise, the social demands of its interventions, for the most varied of cases, have increased exponentially, displaying clear symptoms of a "pop- psychology" that shows no sign of abating (Caparrós, 2002; Rose, 1996; Varela & Álvarez-Uría, 1986). "Pop- psychology" not only occurs in mental healthcare, but also spreads a psychologised rationality for understanding a huge disparity of socio-political issues: poverty; marginalisation; conflict; social success, and so on and so forth. All this finally leads to political— whether state or not— educational, legal or economic actions, which require the intervention of psychologists— or of some psychological or psychosocial knowledge— in a multifarious range of social domains.

This is how the current controversies concerning the legal-administrative regulation of the educational and professional situation of psychology should be understood. Has psychology properly managed the enormous increase in its practical and professional frameworks? This seems to be a key problem, as it is deeply rooted in the diffuse nature of what is known as 'psychological phenomena', and in the sphere of action where expert knowledge of them enables psychology to put in practice. This is a discipline which has always been implemented and spread as a result of the ambivalence between its 'folk' nature and its struggle for scientific and legal recognition. If, on the one hand, this recognition usually relied on biologizing its theoretical and practical principles, psychologisation and pop-psychology had a huge impact on the demand for its academic training and professional scope. In fact, the latter expanded to such an extent that it was operating without any clear regulation in a vast number of both private and institutional places. The instability and lack of protection of psychological practice in healthcare, could also even be viewed as an inherent element of "psy-disciplines" as a whole (Blanco, 2002), the persistent obstacle to the aim of finding scientific answers for an empty, volatile and constantly changing space.

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