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THE PRESENT AND FUTURE OF CLINICAL AND HEALTH PSYCHOLOGY IN SPAIN: AN ALTERNATIVE VIEW

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In our country, there are currently two types of psychologist qualified to practise psychology in the health field: the Specialist Psychologist in Clinical Psychology (PEPC) and the General Health Psychologist (PGS). These qualifications are legally regulated and their accreditation is obtained through two different programs of postgraduate training: the Residential Internship Program (PIR) in the case of the PEPC; and the Master of General Health Psychology (MPGS) in the case of the PGS. These programs are of different lengths (4 years for the PIR and 2 years for the MPGS) and they are accessed after completion of the corresponding degree in Psychology. However, the objectives and the skills to be attained, as well as the content of the training programs, are actually very similar, in spite of the different linguistic denominations used to describe them. On the basis of the existing differences in the terminology and the duration of the programs, some Spanish associations (ANPIR, COP, AEPCP and AEN) defend the position that there should be established between the two qualifications, in addition to a hierarchical structure, a clear boundary with respect to the functions that the two types of psychologist can perform (clinical and specialised versus health and general functions) and of the sectors or contexts in which they can practise (public versus private). In our article, we refute these positions and the reasons on which they are based and we argue extensively in favour of an alternative proposal more in tune with the reality of the facts and with the European context professional accreditation in clinical psychology, in the sense of accepting the existence of the two independent qualifications of clinical psychologists (the PEPC and the PGS), with direct access to both from the degree in Psychology, and with equivalent competencies and professional functions, although with some limitations in the case of the PGS, mainly with respect to the possibility of professional practice in the Spanish National Health System (exclusive to the PEPC) and in their activity, which would be carried out mainly in the private sector.
Key words: *Specialist Psychologist in Clinical Psychology (PEPC), General Health Psychologist (PGS), National Health System (SNS), legal regulation, competencies, public, private, career itinerary.*

En nuestro país existen actualmente dos tipos de psicólogos titulados con competencias para el ejercicio de la psicología en el ámbito sanitario: el Psicólogo Especialista en Psicología Clínica (PEPC) y el Psicólogo General Sanitario (PGS). Estas titulaciones están legalmente reguladas y la acreditación en las mismas se obtiene a través de dos tipos diferentes de programas de formación de posgrado: el Programa de Internado y Residencia (PIR) en el caso de los PEPC; y el Master de Psicología General Sanitaria (MPGS) en el caso del PGS. Estos programas tienen una duración temporal diferente (4 años el PIR y 2 años el MPGS) y a ellos se accede después de la realización de los correspondientes estudios de Grado (o de licenciatura) en Psicología. Sin embargo, tanto los objetivos y las competencias a alcanzar, como el contenido de sus programas de formación, son realmente muy similares, a pesar de las diferentes denominaciones lingüísticas utilizadas para describir los mismos. En base a esas diferencias temporales y terminológicas existentes entre ambos programas, algunas asociaciones españolas (ANPIR, COP, AEPCP y AEN) defienden la postura de que entre ambas titulaciones se debería establecer además de una jerarquización, una delimitación clara respecto de las funciones que pueden realizar ambas (clínicas y especializadas versus sanitarias y generales) y de los ámbitos o contextos en los que pueden ejercerlas (público versus privado). En nuestro artículo rebatimos estas posturas y las razones en las que se basan y argumentamos extensamente en favor de una propuesta alternativa más acorde con la realidad de los hechos y más armónica con el contexto europeo en relación con la acreditación profesional en Psicología Clínica, en el sentido de asumir la existencia de las dos titulaciones independientes de psicólogos clínicos (el PEPC y el PGS), con acceso directo a ambas desde la titulación del Grado en Psicología, y con unas competencias y funciones profesionales equivalentes, aunque con algunas limitaciones en el caso del PGS, principalmente respecto a la posibilidad del ejercicio profesional en el Sistema Nacional de Salud (reservado para los PEPC) y cuya actividad sería ejercida principalmente en el ámbito privado.
Palabras clave: *Psicólogo Especialista en Psicología Clínica (PEPC), Psicólogo General Sanitario (PGS), Sistema Nacional de Salud (SNS), regulación legal, competencias, público, privado, itinerario.*

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INTRODUCTION

In Spain today, there are thousands of psychologists with only a degree in psychology practising as clinical and health psychologists in public schools and, especially, in offices or private consultancies. Until now, these psychologists have been considered competent to practise the profession and we have staunchly defended their right to do so, particularly from within our own professional organization, the Association of Psychologists (College of Psychologists in Spanish, COP), to whom responsibility for doing this should primarily fall. There have been attempts to take this right from them illegally for several years, but it has finally been recognized by the recent amendment to *Law 3/2014 (BOE: 28/03/2014)* whereby a further modification is made to the *"Seventh Additional Provision (Psychologists) of the General Public Health Law 33/2011 (BOE: 05/10/2011)*" in the sense of allowing the continued indefinite practice as Clinical (and Health) Psychologists to all psychology graduates who are practising as such, "... without requiring them (in order to do so) to obtain the title of Specialist Psychologist in Clinical Psychology or that of Master of General Health Psychology, thus avoiding the legal vacuum that would result if it were interpreted that the proprietors of all psychology consultancies/offices (the number of these is very high in in this country) should hold this professional Master's degree, whose general conditions, to which future university curricula must be adapted, were approved very recently by the *Ministerial Order ECD/1070/2013 BOE: 14/06/2013).*

Also, the reform of the aforementioned amendment to the *Law 3/2014* goes even further, guaranteeing the right to continue practising as Clinical (or Health) Psychologists now and in the future within the National System Health (not only in the private sphere) for psychologists who were doing so prior to the adoption of the Law on Social Economy 5/2011 (BOE: 30/03/2011).

The introduction of these new amendments by the Ministry of Health responds to the constitutional mandate of respecting the rights acquired by professional psychologists to practise as clinical and health psychologists due to being psychology graduates prior to the entry into force of the General Law 33/2011 of Public Health, whose transitional period until its definitive adoption ends on October 4 2014, as expressed by the People's Party of Spain in Congress justifying its proposal for the amendment of General Law 33/2011 on Public Health, through the two aforementioned modifications:

> *"The effect of the two provisions on the requirements of training that are prerequisites for the professional practice of psychology in the health sector and the creation of the new regulated and titled health profession of General Health Psychologist, although requiring possession of a university master's degree in General Health Psychology, should not prevent the recognition of rights acquired under the preceding legislation or infringe the principle of non-retroactivity of Article 9.3 of the Spanish Constitution, thereby modifying the seventh additional provision of Law 33/2011 of the 4th October on General Public Health adding (the) two new paragraphs (mentioned above)."*

In this process, the attitude and actions of our collegiate representatives was to defend all psychologists unconditionally, regardless of the sector, public or private, in which they exercise their clinical activity. I still remember, in this sense, the multiple manifestations, with their corresponding banners, in front of the Ministry of Health, led by representatives of the COP, with the rightful claim that psychology should be recognized as a health profession and that psychologists be allowed to continue practising their profession as they had been doing, without retroactively applying such an unfair and unjustified law as the LOPS (2003) which had just been approved by our

Explanatory note: The terms "***Psicología Sanitaria"*** and "***Psicólogo General Sanitario***" included in the name of this new qualification in Spanish have created much confusion due to their vagueness and nonspecificity, because they do not refer to any of the professional specialities or fields of applied psychology that exist worldwide, as discussed in the text. This confusion is clearly apparent when trying to translate the term "Psicólogo General Sanitario" into other languages, as in English here, where it is not possible to find a term that expresses the exact equivalent of its intended meaning in Spanish. Perhaps the closest translation of the term would be "General Practitioner in Health Psychology" or "General Psychological Health Practitioner", although these terms are equally as bizarre as the Spanish term "Psicólogo General Sanitario" itself is to us. Therefore, when translating the terms into English we have been forced to opt for "General Health Psychologist" and "Health Psychology" as the closest versions of the meaning in Spanish, although we are aware that their meaning is not identical to that which the Spanish lawmakers have tried to bestow upon them in the new law. Likewise, the terms "Health Psychologist" and "Clinical Psychologist" are equivalent to "Psicólogo de la Salud" and "Psicólogo Clínico", and exist as professional fields of applied psychology, both within and outside of our country. Therefore, it is incomprehensible that it has not been decided to use these terms to describe this area of specialisation in our country, instead of the non-existent and non-homologizable internationally "Psicólogo General Sanitario".

distinguished politicians, guided by our very own collegial medical institutions, and very far removed from what was happening in other countries in Europe.

Also worth mentioning in this brief historical account is the fact that Specialist Psychologists in Clinical Psychology trained through the PIR program already existed since 1998, long before the LOPS (2003) was adopted, without any conflicts of interest arising until that date between them and the other psychologists who practiced as clinical psychologists in the public or private sector. However, since the approval of the LOPS, things began to change and current conflicts emerged that have gradually increased, always raised unilaterally by PIR Clinical Psychologists Specialists, seeing themselves favoured by the LOPS (2003) with regards to other psychologists, due to the erroneous belief of the Ministry of Health at the time that psychology graduates were not health professionals simply by being graduates, wrongly and illegally applying the aforementioned LOPS retroactively, a fact that, as we have explained at length above, the Ministry of Health has now been forced to rectify (*Law 3/2014; BOE: 28/03/2014*).

Added to this factor, already in itself problematic, was a new event that could apparently complicate things further – a change in attitude of the COP itself, which then went on to accept without resistance the LOPS that it had previously rejected, thus favoring the group of PIR psychologists and at the same time causing disadvantage, to a certain extent, albeit neither intentionally nor consciously, to the rest of the professionals who did not enjoy the privilege of having obtained a place as Specialist Psychologist in Clinical Psychology (PEPC), either directly or homologized by the PIR, who were working as clinical psychologists, mainly in the private sphere.

It is also necessary to recognize, sincerely, that our professional organization has continued throughout the whole of this time to urge the Ministry of Health, through multiple and ongoing efforts, to obtain a solution for the extensive group of non-homologised private clinical psychologists to allow them to continue to practise as health psychologists in the future. The recent approval of Law 3/2014 is also undoubtedly, to some extent, a consequence of these efforts. But at the same time it should also be pointed out that the COP has perhaps not done all it could have done in this area, in the sense of not having shown a more belligerent attitude towards the Ministry of Health with regards to the flagrant violation of the rights of psychologists, denying them the legal right to continue to practise their profession as clinical psychologists, derived from their status as graduates in psychology. For example, the COP could have resorted to legal action against the LOPS (2003), as other professional associations have done, private ones with less power and fewer economic resources than the COP, such as the National Association of Clinical and Health Psychologists (ANPCS in Spanish) which undoubtedly was the one of the main reasons for the recent approval of Law 3/2014.

And the question to be asked in this regard, is why this change of position and attitude has occurred on the part of the COP. The answer to this question may have, in turn, several alternatives: 1) one explanation could possibly be that it has bowed to the pressure exerted by the *National Association of Internal Resident Psychologists* (ANPIR) and associations related to their cause, such as the *Spanish Association for Clinical Psychology and Psychopathology* (AEPCP) and the *Spanish Association of Neuropsychiatry* (AEN); 2) another is that it has genuinely identified with the position of the PIRs, our representatives in the COP being sincerely convinced that the hierarchy, the higher status and the exclusive privileges claimed by the PIRs with respect to other health psychologists, were the most fair and appropriate for our profession. In any case, it can be said that the role of the COP should not in any way be to side with one group or another, but to defend the entire group of psychologists as a whole and especially the group of professionals in the more precarious situation, which is not exactly the case of the PIR psychologists.

In short, the controversy or the paradox we face here deals with the fact that the COP itself (and associations related to it) are now defending the contradiction that psychologists (psychology graduates) who also complete graduate studies in the Master of Health General Psychology (MPGS) would not be able to practise fully as clinical psychologists, on equal footing with PIRs, to whom this right would be reserved exclusively, according to them, assigning to General Healthcare Psychologists (PGS) the role of mediators or almost mere auxiliaries of mediators; when, according to the recently adopted Law 3/2014, current graduates in psychology (with a lower apparent level of training than future General Health Psychologists) have an inalienable right to practise and continue to practise indefinitely, as clinical and health psychologists.

CLINICAL PSYCHOLOGIST AND GENERAL HEALTH PSYCHOLOGIST

Those who advocate the idea of distinguishing and emphasising the possible differences between the

Specialist Psychologist in Clinical Psychology (PEPC) and the General Health Psychologist (PGS) tend to do so on the basis of arguments on the four main alleged differences, which are as follows: 1) the different names given to the qualifications achieved by the two training programs, the Specialist Psychologist in Clinical Psychology (PEPC) and the General Health Psychologist (PGS) in reference to the curious distinctions that it is attempted to establish between the following terminological dichotomies "*clinical versus health*" and "*specialist versus generalist*"; 2) the alleged differential educational content of these programs; 3) the roles and responsibilities supposedly ascribed by law to the two professionals or qualifications, the PEPC and PGS; and 4) the context or sector in which the two types of professional are expected to practise or perform their activity and their roles in the future: *public or private*.

1. The name of the qualification achieved in the two training programs: Specialist Psychologist in Clinical Psychology (PEPC) and General Health Psychologist (PGS).

The first thing to say overall on the alleged differences between the two qualifications is that they are mainly concerned with a pure and simple "nominalist issue" on which an entire argument has been established, articulated naively, although the positions are not exempt of interest, acknowledged to a greater or lesser extent on the part of the groups that espouse those positions. These controversies or terminological dichotomies are mainly focused on the distinction between the terms "***clinical*** *versus* ***health***" and "***specialist*** *versus* ***generalist***".

*1.1. The supposed distinction between the titles "**Clinical Psychologist**" and "**Health Psychologist**".*

If it were not for the major practical and professional implications that may arise from the debate that we are dealing with here, for psychology and for the many professionals who practise it, I would venture to put down to monumental banality the bright idea that the fathers of the current legislation had by insisting on establishing unreasonably the existence of the two qualifications of the PEPC and PGS, mainly based on the different name attached to each of them. And what is even worse, the effort they have spent in trying to justify their first gaffe, resorting to subterfuge to try to find some linguistic basis on which to support their unjustified error.

The first proof of what we are saying is clearly seen in the various adjectives used to distinguish and qualify artificially the two types of psychologist: the PEPC (PIR) and PGS. Thus, the psychologist with postgraduate training via the PIR is distinguished or is qualified with the adjective "*clinical*" while the psychologist trained via the university postgraduate Master in PGS is allotted the intentionally unspecific and supposedly less valuable adjective of "*health*". And the question that immediately springs to mind is what does it mean in this context and what does it add to the clarification of this debate, the use of a term that is so vague, so general and so irrelevant to psychology as that of *"health"*, non-existent, more's the shame, as a qualifier of any applied field or professional specialisation of psychology in the entire world, for the simple and persuasive reason that psychology is regarded widely as a health profession in the rest of the world.

Indeed, the term "health" is a generic description that simply denotes relation to health care or the health service, but it can also be and is often used as a generic term to describe a limitless and varied number of contexts and situations, including not only the healthcare context, but also the general field of hygiene and cleanliness. But in reality, the two terms *clinical* and *health* are largely equivalent and their meanings are related, since everything that is clinical is health-related and vice versa. It is even more difficult to attempt to establish a certain hierarchy between the two terms and the activities that they indicate, and a hierarchy could even be established in the opposite direction to that intended by the proponents of this distinction, since the term "health" may be considered broader than the term "clinical" which would be included within the meaning of "health".

*1.2. The intended and supposed distinction between "**specialist**" and "**generalist**"*

Another controversial issue is the constant insistence that the PEPC (PIR) psychologist is a "*specialist*" and the other type of psychologist, the PGS, is a "*generalist*". See the ongoing and successive statements by the President of the General Council of Psychology in Spain on this issue, in the official publication of the COP (*Infocop*, 2012, 2013, 2014). And to justify this position, reference is made only to the unfortunate name used officially by the Ministries of Health and Education to refer to these qualifications, disregarding the specific contents of the training programs followed by the two types of professionals. In this regard, it is worth noting how unfortunate the chosen name of "General Health Psychologist" is, not homologous with any of the existing psychology degrees in the world, and even so less in Europe, developed in the

shadow of medicine, the image and likeness of the archaic figure of the General Practitioner, although the figure of the General Practitioner does not even exist now, having become the present-day Specialist in Family and Community Medicine, and in no way inspired by the international context of applied clinical psychology.

But as much as this nominalist issue is insisted upon, the facts do not cease to be what they are and the General Health Psychologist (PGS) is a genuine clinical psychologist and specialist in the same way as the PEPC psychologist trained via the PIR. And to justify this statement it may be sufficient to observe the objectives and skills to be attained and the curriculum followed by the postgraduate training programmes of the *Master's degree in General Health Psychology*, currently accredited in our country. It is similar to the previous *Official Master's degree in (Clinical and) Health Psychology* from which it derives, and its contents, as well as the teaching methodology used, are in accordance with the European guidelines reflected in the objectives and skills required for clinical psychologists in Europe to guarantee their training and professional competence and to be certified as such by the European Federation of Psychologists' Associations (EFPA) through the Diploma or *European Certificate of Psychology* (EuroPsy) issued by the same organization, which trains and certifies individuals to practice clinical psychology in Europe, whether it is known as "health" or "clinical". Fortunately, these terms are not discriminative in Europe, as some insist on it being the case in Spain. Furthermore, neither they nor their graduate training program are labelled with the term *generalist psychologist*.

In any case, it is suffice to note the specific content of the training programs of the General Health Psychologists (PGS) to conclude that this content is not at all generalist, but rather an authentic specialisation in Clinical and Health Psychology, similar to that followed in the training of the PIR Psychologists, when the two training programs are compared with each other, as can be seen in the more detailed comparison we make between the two training programs in the following section.

Similarly, it is also surprising that in the PIR Training Program in Psychology there is only one single speciality (that of the clinical psychologist), whereas in medicine, for example, a total of 47 MIR specialities are included. How can we explain that the practical and specialised applications of psychology in the healthcare field and health only lead to one single specialisation? And the possible answer may lie in the PIR training, as argued by those who defend that position, but on the other hand, there is the case of the General Health Psychologist (PGS), which either is not really a specialisation but rather a generalist training, or its educational content itself is as specialised and appropriate for a specialist as the PGS.

In the same vein, it is worth recalling the apparently very successful arguments put forward by the National Association of Clinical and Health Psychologists (ANPCS, 2012, 2013) that the PIR cannot be considered a true specialist, given the disparity and the training in general content that these psychologists receive, with little depth in any specific or specialised content. Furthermore it was proposed that in the PIR training program itself there should be different future routes or curricula that are more specialised in topics or fields such as addictions, child and adolescent disorders, the elderly, sexual disorders, marital problems, and many more.

2. The different contents of the training programs of Internal Resident Psychologists (PIR) and the General Health Psychologist (PGS)

A complementary argument, but one that is equally strong, against the distinction between the two postgraduate programs in the sense of a greater or lesser specialisation between the two, may be to compare the specific content taught in the two training programs, that of the PIR and the Master in PGS, in order to observe the possible similarities and differences therein. For this purpose, we include here the content declared in the *Order SAS/1620/2009 (BOE:17/06/2009)* by which the training program in the specialty of Clinical Psychology (PIR) was approved and published, describing the different specific contents of the training program; and the contents of the *Master's training program of General Health Psychology (MPGS) (seventh additional provision of Law 33/2011 of Public Health)*.

In order to make this comparison, and to do so in the most practical and operational way, we will use, simply as an example, the Training Program of the Master's in General Health Psychology (MPGS) from our own Faculty of Psychology at the Autonomous University of Madrid (UAM) currently accredited by the National Assessment Agency (ANECA), very similar to the other psychology faculties that currently have accreditation, with a total of 90 ECTS (European credits) equivalent to 2,250 teaching hours of which 750 hours are devoted to external internships (30 ECTS) and 300 hours (12 ECTS) to the development of an applied research clinical study (TFM) that is to be presented, defended and evaluated publicly before, and by an

independent panel. It may also be pertinent to note in this regard that both the content and the teaching load included in the training program of the Master PGS are real and accurately respond to the content taught therein and not a mere declaration of intent or an imaginary or ideal theoretical program, as is often the case in other training programs. The teaching content of the PGS Master's Program is also taught by academically qualified teachers specialised in imparting the relevant content.

For a description of the *PIR training program*, we will use the official program, the only one in existence for the whole Spanish State (*Order SAS / 1620/2009*), with a total duration of four years and which includes, besides the theoretical content of the training program, a program of rotations through different healthcare services, as the main feature of the practical training. However, it should be noted that, in the case of the content of the PIR training program, neither the amount of hours nor the number of teaching credits that are dedicated to the delivery of the content of the program as a whole is specified. The specific contents of the theoretical training program of the PIR are also not specified, it only being stated that the contents will be taught over the four years of the total duration of the PIR. And the same is true of the lecturers who must teach the different educational contents of the program, about whom no information is given regarding their qualifications or scientific or professional suitability to do so, except in the case of the Personal Tutor who should be a PEPC, and the unit or service, usually of psychiatry, of the hospital to which the Tutor is attached.

These MPGS and PIR training programs can be seen in *Table 1* and *Table 2*, respectively, provided below. And as shown by this comparison, it is surprising that, as we discussed above, the PIR psychologist is named *specialist* and not the PGS, when the contents of the training programs of the two are actually very similar.

As shown, the two training programs have not only many similarities and equivalences, but also, if anything, greater generality of the contents can be observed in the PIR Program, compared with the MPGS program, which appears to be more of a review and extension of the training content of the psychology degree than a genuine specialisation, except in regard to the topic or section of the professional internships of both programs, where a clear distinction is observed, in favour of the PIR program, due to its inclusion of rotations through different healthcare services, much more varied and of longer duration. The Master of PGS is clearly deficient on this issue and should be expanded in the future.

3. The competencies and functions ascribed to both the professionals and the qualifications: Specialist Psychologist in Clinical Psychology (PEPC) and the General Health Psychologist (PGS).

As in the case of the training content just discussed, a coincidence is also observed in relation to the objectives and competencies declared to be attained, both general and specific, through the training followed by the two programs, the PIR and the MPGS, where in comparing them we observe considerable parallelism between the two, in spite of the insistence by proponents of the alleged differences between them and, especially, of the superiority of the PIR programme over the PGS Master.

TABLE 1
THE STRUCTURE AND CONTENT OF THE TRAINING PROGRAM OF THE MASTER'S DEGREE IN GENERAL HEALTH PSYCHOLOGY AT THE AUTONOMOUS UNIVERSITY OF MADRID (UAM)

MODULE 1: The scientific and professional foundations of Health Psychology:	✔The professional foundations of Health Psychology (3) (*) ✔The scientific fundamentals of Health Psychology (3)
MODULE 2: Assessment, diagnosis and intervention in Health Psychology:	✔Assessment, diagnosis and intervention in adults (6) ✔Assessment, diagnosis and intervention in children and adolescents (3) ✔Assessment, diagnosis and intervention in elderly people (3) ✔Health Psychology. Theoretical foundations, evaluation and intervention (6) ✔Applied methodology in the field of general health psychology (3) ✔Neuropsychological assessment and intervention (3)
MODULE 3: Skills of the General Health Psychologist:	✔Skills of the General Health Psychologist (6)
MODULE 4: Optional subjects:	✔Update on psychological therapies ✔Couples, families and sexuality ✔Positive Psychology and Health ✔Neuropsychological disorders in clinical populations ✔Occupational health psychology ✔Intervention in crises, emergencies and disasters ✔Prevention, detection and intervention in problems of violence and abuse ✔Rehabilitation in chronic health disorders ✔Neurodevelopmental disorders ✔Health Psychology: Seminar
MODULE 5: Optional subject areas aimed at achieving the Ph.D.:	✔Advanced Research Methods in Clinical and Health Psychology ✔Update on Clinical and Health Psychology ✔Update on neuroscience and the psychology of cognition, emotion and behaviour
MODULE 6: External work placements:	1. Mandatory external work placements carried out in accredited public and private centres (30 ECTS = 750 hours)
MODULE 7: Master's dissertation:	2. Master's dissertation (TFM in Spanish) presented and defended publicly before the corresponding tribunal (12 ECTS = 200 hours)

(*) **Note**: The number included in the parentheses following each item indicates the number of ECTS credits dedicated to the delivery of the teaching content.

TABLE 2
THE STRUCTURE AND CONTENT OF THE TRAINING PROGRAM OF THE SPECIALIST PSYCHOLOGIST IN CLINICAL PSYCHOLOGY (PIR)

4-PART BASIC TRAINING CONTENT:

1. **General theoretical training** common to other specialties in health sciences to be carried out over the four years of residency.
2. **General theoretical training in clinical psychology** to be carried out over the four years of residency.
3. **Clinical-care contents.** Basic and specific rotations linked to objectives, activities and theoretical knowledge.
4. **Continuing Care.**

1. GENERAL THEORETICAL TRAINING COMMON TO OTHER SPECIALITIES IN HEALTH SCIENCES:	✔Bioethics, care ethics and professional ethics. ✔Health organisation and legislation. ✔Clinical management ✔Research methodology
2. GENERAL THEORETICAL TRAINING IN CLINICAL PSYCHOLOGY (The program is aimed at increasing knowledge of the conceptual, methodological and research aspects related to mental and behavioural disorders and illnesses)	
MODULE 1: Specific conceptual, legal and institutional frameworks of Clinical Psychology:	✔The code of ethics for the psychologist. ✔Legal and forensic clinical psychology. ✔The process of scientific research in clinical psychology. ✔Assessment of efficacy and efficiency of the treatments and programs of assessment, diagnosis and intervention in clinical psychology.
MODULE 2: Clinical evaluation and diagnosis:	✔The clinical interview and psychological and psychopathological examination. ✔The clinical history. ✔Techniques, strategies and procedures for psychological evaluation and diagnosis. ✔The diagnostic process in clinical psychology. ✔The clinical report. ✔The expert report. ✔Criteria and systems of psychopathological diagnosis and classification of mental illnesses and disorders. ✔Special characteristics of the clinical assessment and diagnosis of people with intellectual disabilities and mental disorders. ✔Special characteristics of psychological assessment in people with physical illnesses. ✔Special characteristics of clinical evaluation and diagnosis of people at risk of social exclusion.
MODULE 3: Clinical training in mental disorders and illness, and behaviour:	✔Bio-psycho-social model of health and disease. ✔Update on the psychopathology of processes, functions, and mental, emotional and relational activities, and behaviour. ✔Differences between mental and behavioural disorders and transitional alterations and/or alterations linked to specific life events. ✔Cultural, social, and epidemiological determinants of mental, emotional, cognitive, behavioural and relational disorders.
MODULE 4: Psychotherapy and procedures of psychological intervention and treatment:	✔Therapeutic process and psychotherapeutic skills. ✔Communication skills and strategies. ✔Therapeutic efficacy and analysis of the differential effectiveness of psychological therapies. ✔The efficacy of psychological treatments, drug treatments and combined treatments. ✔Psychotherapy and cognitive-behavioural intervention procedures and psychological treatment. ✔Promoting mental health. ✔Levels of intervention in psychotherapy and other psychological treatment procedures: individual; group; couple and family; institutional; community. ✔Psychopharmacology.
RESEARCH IN CLINICAL PSYCHOLOGY:	✔Research in Clinical Psychology
3. CLINICAL CARE CONTENTS: Program of basic and specific **rotations** in different care services and units in community mental health, inpatient units and rehabilitation units:	✔Community care, outpatient and primary care support. ✔Primary care. ✔Addictions. ✔Rehabilitation. ✔Hospitalization and emergency department. ✔Clinical health psychology. Inter-Department Liaison and Attention to Referred Cases ✔Child and Adolescent Clinical Psychology. ✔Programs for the development of specific training areas. ✔Free choice rotation.

Although we do not include here the list of these objectives and competencies, so as not to overload this article, we refer those interested in this finding to the specific references listed above on the two types of programs. *(Order SAS/1620/2009; BOE: 17/06/2009, on the training program in the speciality of Clinical Psychology (PIR) and Ministerial Order ECD/1070/2013; BOE: 14/06/2013, in the case of the Master's Degree in General Health Psychology).*

On this issue, it should also be noted that the original text of the Royal Decree (LOPS, 2003) that defines the roles and general competencies assigned to the two types of practitioner is truly confusing and unspecific and a true reflection of the effect of the influences to which the Ministry of Health has been exposed by certain pressure groups existing in medicine and psychology and, of course, far from the opinion widely and repeatedly expressed by the Faculties of Psychology, through their highest organisation, the State Conference of Deans of the Faculties of Psychology.

And on the content and wording of the official text that defines these functions (or rather, that vaguely mentions them) the only thing to be said is that it creates more confusion than it aims to prevent. In the case of General Health Psychologist (PGS) excessive concern can be observed on the part of the legislator for the non-use of certain terms such as: diagnosis, disorder, illness, treatment, clinical or specialist, among others; proposing instead as euphemistic alternatives, terms which are in fact equivalent, such as evaluation, intervention, behavioural problems, research, or improvement in health, in the definition of the roles of the General Health Psychologist (PGS) with obsessive concern to avoid overlapping or competing with the roles ascribed to the PIR, and to avoid the hypothetical intrusion that they are so obstinately concerned about preserving, albeit without success at all. Observe the peculiarities to which we refer in the definition of these roles in the official document adopted on the profession of General Health Psychologist (PGS) in the legendary *Seventh Additional Provision of Law 33/2011 on Public Health*, where it says that the responsibility of the General Health Psychologist (PGS) is:

> *"To conduct psychological research, evaluations and interventions on people's aspects of behaviour and activity that influence the promotion and improvement of their overall health, provided that such activities do not require specialised care by other health care professionals."*

Compare this definition with the functions of the Specialist Psychologist in Clinical Psychology, trained via the PIR according to *Order SAS/1620/2009 (BOE: 17/06/2009)*, which approves the training program of the speciality in Clinic Psychology, where it says:

> *"Clinical Psychology is a health speciality of psychology that deals with the psychological and relational processes and phenomena involved in the processes of health-illness of humans* [… and its scope] *encompasses the research, explanation, understanding, prevention, evaluation, diagnosis, treatment and rehabilitation of mental disorders, as well as psychological, behavioural, and relational phenomena and processes affecting the health and illness of individuals, from a comprehensive and multi-determined concept of human health and illness. In order to do this, it uses demonstrated and verifiable processes of scientific research."*

However, regardless of what the text of the Law says, or what some interpret it as saying, Health Psychologists (whether PIR or PGS) will not cease to practise their profession using the techniques, methodology and functions of evaluation, diagnosis, explanation, treatment and prevention appropriate to them and which they have learned throughout their undergraduate and postgraduate training, as Spanish psychologists have been doing until now, just like other clinical and health psychologists all around the world.

An unquestionably stubborn and paradoxical demonstration of the some people's commitment to defend these differences to the end is the recent administrative appeal filed by the ANPIR Association against the Ministries of Education and Health, and against the Master's in General Health Psychology (MPGS) and the degree in General Health Psychology (PGS) based on this terminological nonsense concerning the supposed differences between "diagnosis and evaluation" and "treatment and intervention", emulating exactly the same arguments used by the psychiatrists (Spanish Association of Psychiatry) in the administrative appeal filed in 1998 against the implementation of the PIR program and against the figure of the Specialist Psychologist in Clinical Psychology (PEPC). In this sense, it is truly ironic that it is the PIR psychologists who are now practising in the role of psychiatrists in their appeal against the PGS, just as the PGS appealed against them in the past and with the same arguments, although fortunately without success in that case, due to the fact

that, amongst other reasons, many of us defended them, serving as expert witnesses in the court proceedings as professors of clinical psychology in conjunction with the COP itself, just as we expect to happen, and even more rightly so, in the current appeal. As the classic saying goes, "*Those who do not remember and learn from history, run the risk of repeating its mistakes.*"

In this regard, a truly hopeful and meaningful fact to settle this controversy definitively is provided by the recent report submitted on 20/05/2014 by the State Attorney at the National Court in response to the aforementioned administrative appeal of the ANPIR Association against the MPGS and PGS (Ordinary Procedure No. 361/2013), the conclusions of which read as follows:

> *"In summary, from the review of the additional provision to Law 33/2011 it is accredited that, in the current regulation, no activity has been established as exclusive to clinical psychologists, the only exclusivity being that they provide their services in the Spanish National Health System and public-private centres"*
>
> *"That being so, it must be concluded that General Health Psychologists may, within their field of activity, make diagnoses, treat disorders and behavioural or mental diseases (including those listed under "External practicals", point 4, concerning addictions, marital therapy, etc., the removal of which being requested in the claimant's statement of case) and have patients (since Law 41/2002, of 14 November, regulating patient autonomy defined as the person receiving health care and who is under professional care for the maintenance or recovery of his health, which can be asserted in the present case). Therefore, according to this representative, none of the changes requested in the claimant's statement of case can be complied with. For these reasons, there is no reason why the practicals of General Health Psychologists cannot be carried out in centres within the National Health System".*

4. *The sector or context of work for the PIR and PGS: public or private?*

Another curious controversy or confusion that has also arisen around this topic is the sector or context in which it is postulated or supposed that the two types of health psychologists, the PIR and PGS, perform their professional functions, associated with the terms *public* and *private*. In this sense, it is argued that the PGS should only exercise their activity in the *private* sphere, reserving the *public* domain exclusively for PIR psychologists, in the Spanish National Health Service or in public-private centres. In this regard, it is worth mentioning the confusion or error observed immediately in this argument, as the word *public* is used as a synonym or equivalent for the term *state* or belonging to the Spanish National Health System (SNS) and, additionally, everything that is not included or directly related to the SNS is considered, by definition, as non-public or private. Thus the mistake is made of using the two terms, *public* and *state*, as similar or equivalent.

But, obviously, the universe that encompasses the public sector is much larger than that of the state sector itself or the SNS; the social, community and public activity that psychologists can perform is not reserved exclusively to the Spanish National Health System (SNS), even though in the Spanish health context the two terms, *public* and *SNS* coincide considerably. We might, however, be right to fear that this may change if the current privatisation policies of the parties that govern us continue.

Elaborating on this argument, it should also be said, sticking strictly to the specifications in the Law, that the General Health Psychologist (PGS) can not only practise in the private sector, but also in the public sector, provided that this activity is not included in the Spanish National Health System, which could mean municipal or regional spheres, associations of various kinds, NGOs, private hospitals not under contract with the SNS, among many others. And, of course, they can practise their profession in more specific contexts, such as consultancies or private cabinets, which is usually the main applied area in which they practise today in our country.

It is also worth noting that this is what usually happens in other European countries around us, where the title of Clinical Psychologist or equivalent is regulated, where the *psychologists* that are *accredited* as clinical psychologists tend to follow a university training program, either a Master or a postgraduate course similar in content to our Master in PGS, which allows them to practise as clinical psychologists although they may simply be called *accredited psychologists* (not generalists, as some say maliciously). The program lasts for three years, of which at least one is usually tutored professional clinical practice, to make a total duration of about six years: the three years of the degree (Bachelor's) plus another three years of postgraduate training or Master's degree. Furthermore, it should also be mentioned that the clinical psychologists trained in this way can, in the case of some European countries, achieve the additional degree of

Doctor, as well as Clinical Psychologist, as part of their training program or specialisation and in some countries, such as the UK it is necessary to complete the university PhD program and attain the level of Doctor in order to practise and use the title of Clinical Psychologist.

THE QUESTION OF THE PROPOSED ESTABLISHMENT OF A MANDATORY TEACHING ITINERARY BETWEEN *"DEGREE - MPGS - PIR"*.

Another matter of controversy, on which the ANPIR association and our own COP are also extremely obstinate, relates to the proposal of the possible future requirement of having to do the Master of PGS as a compulsory step after the degree in order to access the PIR training program and the certification of PEPC, without maintaining the possibility, as it currently stands, of accessing the PIR directly after the psychology degree.

The main reasons given by the proponents of this position are largely the same as we have been discussing throughout this article and can, in short, be summarized in the following four points: 1) the studies of the PIR program to obtain the PEPC qualification have a longer duration than that of the Master to attain the PGS title (4 years for the PIR, versus 2 years for the MPGS); 2) the difference in the duration of the courses implies a different level of expertise between the two, *Specialist Psychologist in Clinical Psychology* (PEPC) and *General Health Psychologist* (PGS), and therefore a hierarchy should be established between the two in favour of the PEPC (which would be the fully specialised clinical psychologist) and there should be a number of limitations on the practise of clinical-health psychology on the part of the PGS, both in their functions and in the field in which they may practise, in respect of the PEPC, to whom they will be subordinates; 3) These differences would be also endorsed by the different name assigned by law to the two types of health psychologist, especially in reference to the terms *clinical* and *specialist* included in the case of the name or title of *Specialist Psychologist in Clinical Psychology*, but not in that of the *General Health Psychologist*, to whom the more unspecific terms of *general* and *health* are ascribed instead; 4) For these reasons, we conclude that both the training and the degree obtained by the PGS are of a lower level or category than those of the PEPC and therefore the PGS is not adequately prepared to perform the majority of the activities and professional functions of the PEPC, and therefore it is proposed that the completion of the Master's degree in PGS should be a prerequisite for accessing the degree of PEPC, expanding the training period of a PEPC clinical psychologist from the current 8 years (degree + PIR) to a total duration of 10 years (degree + MPGS + PIR), clearly disproportionate to the standards of specialised training for psychologists throughout Europe.

These arguments or reasons used to defend the need to establish a hierarchy, a differential status and competencies and functions equally shared between PEPC and PGS psychologists can be rebutted briefly, as we have justified at much greater length previously (Carrobles, 2012, 2013 and 2014) based on the following facts and reasons:

1. Although the duration of the two training programs is undoubtedly a criterion to consider, this is an extremely poor criterion upon which to establish the distinction between the two types of psychologist, it being more relevant to consider the specific content of the programs. And when this comparison is made, a great similarity between the two is observed as well as equally specialised content, therefore failing to justify the aim to restrict the functions of PGS psychologists, their subordination to the PEPC and the intention of not considering them to be authentic clinical psychologists.
2. The argument of different verbal or nominal labels used legally to designate the two types of health psychologists, with the aim of qualifying and defining their roles and competencies ("*generalist* versus *specialist*" and "*clinical* versus *health*"), makes no real scientific or professional sense, as we have previously argued, being nothing more than mere fallacies or linguistic dichotomies artificially created to try and justify the artificial hierarchy which is sought to be established between the PEPC and the PGS.
3. The analysed data allow us to conclude that the level of education achieved by the PGS, through the university studies of the Master's degree in PGS, is adequate and sufficient to provide all the functions of a clinical psychologist, similar to the PEPC, regardless of the fact that the longer duration of the training period and the higher level of qualification achieved by the PEPC may involve other curricular merits or added professional benefits.
4. Therefore, we reject the proposal of the ANPIR Association and the COP to establish a hierarchy and the gradual educational itinerary proposed between the degree, the MPGS and the PIR, with a duration of 10 years, and instead we defend the current path of direct access from the degree to the two existing postgraduate training programs, the PIR and the

MPGS, as this is the most parsimonious and the most homologous and consistent with the training programs of specialist clinical psychologists in most European countries and the world.

CONCLUSIONS

In conclusion, we propose that the two existing figures of health psychologists are maintained: the PEPC and PGS, with different routes and duration of training, but with a clear autonomy and professional independence between them and with all the credentials for both to fully perform the functions of a clinical psychologist, although according to current legislation, the practice of the profession of clinical psychologist in the context of the Spanish National Health System (SNS) is currently reserved exclusively for Psychologists Specialists in Clinical Psychology (PEPC). This might not necessarily be the case in the future, however.

The inclusion of the PEPC in the context of the Spanish National Health System (SNS) especially in the mental health service or psychiatry, can be seen as positive and even coherent due to the investment and supervision the state itself contributes to the training of the PEPC through the PIR program, just as it does with other health professionals: doctors, nurses, pharmacists, etc. But what is clearly incomprehensible, at least in the case of the training of clinical psychologists, is the current situation in our country where the number of PIR places convened annually (127 in 2014) is truly negligible given the existing needs for psychological care in our country, with rates of mental or behavioural disorders close to 40 per cent, according to the most recent studies existing on the subject (Gili et al, 2012; Wittchen et al., 2011) and the lack of clinical psychologists in public centres that can attend to them, estimated at a deficit of about 76% compared with the average occupancy of clinical psychologists in European countries, according to a recent study by the WHO (2005). The lack or the current need for specialist clinical psychologists in the Spanish National Health System is calculated at around 8,000. In the light of this, how can we explain that the state, which invests in training specialists to be well qualified in clinical psychology, does not commit, in parallel, to hiring or contracting them within the SNS itself upon completion of this training, as often happens in other health professions with residential training with much greater frequency than in the case of psychology?

This precarious employment situation, which the PIR clinical psychologists also suffer upon completion of their four year training program, accessed by overcoming stiff opposition to obtain one of the few places offered, may also explain much of the negative attitude and belligerence shown by the ANPIR association toward the new figure of the PGS, trained by the university through the Master's degree in PGS, mistakenly seeing them as rivals in the current precarious labour market into which they are pushed, even in the private sector, faced with the impossibility of finding an opportunity that they should find in the public sphere of the SNS reserved exclusively for them.

However, no matter how understandable the situation of employment insecurity is to us, which PIR psychologists are also experiencing, we must remind them that their real enemy is not, nor should it be, the PGS psychologists who are ultimately in a much more precarious situation than they are, but rather the state that does not offer them the opportunity to return the favour or the perks given to them in funding their education technically and financially through the PIR program employing them later to provide services within the SNS. In this sense, my proposal is to join forces and form a common front between the COP, the universities, the scientific and professional associations and the whole of the profession of psychology in our country, to demand that the Ministry of Health urgently convenes spaces for clinical and health psychologists in public health centres and hospitals throughout the country in order to alleviate the enormous suffering and the high economic cost that mental disorders are causing today in our country.

In any case, it is necessary to stress the obvious convenience of the existence of both types of clinical health psychologists, the PEPC and PGS, especially if we are to give priority to the need for clinical and psychological help of a very significant part of the Spanish population. We must put aside our own differences and interests, however understandable and worthy they may seem to us, and, as we say, both types of psychologists are necessary and, realistically, those most likely to be able to contribute more in the short term to the solution of this problem are the PGS, given the possibility of a larger contingent of them being trained by the psychology faculties, compared with the forecast of the allocation of PIR positions by the Ministry of Health. In this sense, the forecast of the allocation of places to study a Master's degree in PGS in the 17 psychology faculties currently accredited by the ANECA for the 2014-2015 course will be 1,500 places, a number which will be increased in successive years as the other faculties, from

the 47 existing in Spain who wish to do so, obtain the appropriate accreditation or verification.

However, given the distinction that we previously established between the public sector and the state sector or the Spanish National Health System (SNS), it is also reasonable to contemplate the inclusion of PGS psychologists in health centres, mainly associated with non-specialist primary care services, where patients are attended with different medical health problems combined with psychological problems, which do not require specialised care by PEPC psychologists, located in the services or units of mental health or psychiatry. Such a measure would result in a multitude of benefits and advantages, not only to improve the employment of the PEPC and PGS psychologists, (a study conducted in Spain by the SEPCyS Association (2011) estimates that 20,000 psychologists could be employed), but also in the overall health of the Spanish population, especially in the almost 40% currently suffering clinical problems or disorders, and with considerable economic benefits associated to the Spanish health system if we take as a reference what has happened in other neighbouring countries such as the United Kingdom. There the study entitled "*Improving Access to Psychological Therapies*" (Clark et al, 2009; *National Health Service*, 2013; Richards & Borglin, 2011) coordinated by the English National Health Service (NHS), with an investment of hundreds of millions of euros, is becoming an undisputed economic and social success and, as mentioned elsewhere (Carrobles, 2014), it can be taken as a benchmark for professional health psychology and the extension of the applications of proven efficacious cognitive-behavioural psychological therapies to different types of problems or psychological disorders such as anxiety and depression. It is currently being extended to other clinical areas and problems in the general population.

On the subject of this promising field of applied psychology in primary care centres or consultancies in health centres and the fierce opposition that the ANPIR Association and some other of the abovementioned associations related to their cause maintain regarding the possibility of future PGS psychologists being able to practise their clinical-healthcare activity in health centres, it is pertinent to mention what seems to be starting to happen in these centres today in our country, where other professionals much less qualified to address these problems, such as nurses and doctors themselves, are taking on this activity instead of health psychologists, the qualified professionals that should be required to do so. To demonstrate this fact, we include below a quotation from the press release of the *Conselleria de Sanitat de la Comunitat Valenciana [*Valencia region Ministry of Health*](2014)*, announcing the launch at the General Hospital of Valencia of an intervention program by teams of primary care for patients with major depression. As can be seen, the text of the press release is perfectly explicit and requires no further clarification, simply to add that this may be the future to be expected for clinical and health psychology in our country if some people persist in further complicating the work of all health psychologists in the vast field of clinical and health problems regardless of whether the context or field in which they manifest themselves is exclusive to a particular professional.

Press release announcing the program: *"The Department of Health - Valencia General Hospital has launched a new medical program to improve the detection and diagnostic accuracy of major depression in primary care consultancies. This program, which is implemented for the first time in the Valencia region, has a clear collaborative nature since it operates on the basis of volunteer teams of doctors and nurses in primary care and mental health.*

Characteristics of the program: *When the primary care physician detects that a patient has depression, he or she gives the patient a questionnaire to fill out. Thus the depression is confirmed or not. If the patient is confirmed to be depressed, the doctor refers the patient to consult a primary care nurse to perform a formal intervention on the patient, consisting of activation and/or problem solving therapies."*

In spite of situations like this, and the bleak future that they herald for Psychology and Spanish society itself, there are some, such as the ANPIR Association, that continue to insist and even resort to legal action against the very existence of the PGS and against the possibility that they may practise as clinical psychologists on equal grounds with the PEPC, when if they do not practise, it will be less qualified professionals who supplant us, although this does not seem to affect them or make them see reason.

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