Surviving in Psychiatry as a Systemic Therapist

Paolo Bertrando
Episteme Centre, Turin, Italy

Although family therapy was born to deal with problems posed by severe mental disorders, systemic therapists today tend to drift away from the field of psychiatry. The author refers to his own experience in psychiatry to argue in favour of the presence of the systemic model within the field: systemic understanding might be precious to counterbalance the tendency toward too easy a reliance on bio-psychiatry and pharmacology. In turn, keeping close to psychiatry and to its problems can be useful to systemic therapists, by involving them in social and epistemological queries that are otherwise extraneous to professionals mainly devoted to private practice.

Keywords: psychiatry, systemic work, expressed emotion

I decided to become a psychiatrist as early as 1978. At the time, in Italy, the interest in social psychiatry was at its peak, and Franco Basaglia was the person most instrumental in bringing the ideas of antipsychiatry and critical psychiatry into the Italian mainstream. In 1978, the '180' Act was passed, deciding to substitute the institution of mental hospitals with psychiatric wards in general hospitals and community services. This was a revolution for a psychiatric system that until then had been firmly rooted in custodial ideology. This is probably why the interest of most socially and culture-oriented young medical students turned toward psychiatry.

Being a young medical student, I turned to psychiatry driven by the writings of authors such as Michel Foucault, widely read at the time in Europe:

> The legends of Pinel and Tuke transmit mythical values … But beneath the myths themselves, there was an operation, or rather a series of operations, which silently organised the world of the asylum, the methods of cure, and at the same time the concrete experience of madness. (Foucault, 1961, p. v)

An earlier version of this article was presented at the Australian Family Therapy Conference, Brisbane, 2008, with the title 'How I Managed to Stay in Psychiatry and Survive as a Systemic Therapist'.

Address for correspondence: Paolo Bertrando, piazza S. Agostino 22, 20123, Milano, Italy. E-mail: studioepisteme@gmail.com

And of course Basaglia: 'The psychiatrist, in fulfilling his professional duty, is physician and policeman, since his action, presumed as therapeutic, participate both in the medical and penal ideology of the social organisation of which he is an active member' (Basaglia & Basaglia Ongaro, 1971, p. 10).

As a psychiatry student, I inhabited a world of contradictions. Differences were already emerging between psychiatric community services and hospital wards, oriented toward social and psychodynamic practices, and academic psychiatry, already geared toward biological and operational psychiatry (the 'biological revolution' and the 'diagnostic revolution' of DSM III, both emerging around 1980). I discovered that the spirit of the '180' Act was strong in psychiatric services, but rather weak at the university, where nobody had forgotten the old quote by Wilhelm Griesinger, the 18th century neuroanatomist: 'Psychological diseases are diseases of the brain. … Insanity is merely a symptom complex of various anomalous states of the brain'. The most promising (or so they told me) line of research in the study of schizophrenia was the analysis of CAT-scans (at the time, there was no magnetic resonance: this was the 'Royal way' for the understanding the brain).

The Contribution of Expressed Emotion

When I began my quest for a postgraduate dissertation, I was already out of love with psychoanalytic psychiatry. Long hours of discussions in hospital wards had shown me that, in most cases, psychoanalytic concepts were used to feel smart and have bright ideas; then there was a falling back to prescribing the same medication to the same patients. I literally stumbled on family research by chance: there was a professor who had decided to begin research on expressed emotion, and that was the only possibility at the time to obtain a thesis on social psychiatry. I must confess I never had any previous special interest in families and family research, but the field was at least very close to my areas of interest.

Working on expressed emotion was important to understand what kind of family theory was feasible for psychiatry around 1986. Expressed emotion was a construct derived inductively from psychosocial research (see Brown, 1985), thus avoiding the prejudices psychiatrist were beginning to develop against any family theory. At the same time, it was operationally very well defined, thus allowing planning of good experimental studies (Leff & Vaughn, 1985). In other words, expressed emotion was (and is) theoretically weak and methodologically strong — which is a perfect position if we want to put aside grand theories in order to focus on practice. Moreover, it was basically an individual measure (it was applied to individual family members rather than to families as a whole), thus suiting the individualistic and piecemeal thinking then favoured by psychiatric researchers.

Being, in a way, agnostic as to causes of mental illness, expressed emotion was also compatible with fashionable theories of the period: with all its emphasis on practice and concreteness, psychiatry cannot do without theories. At the time, the favoured ones were Engel's (1977) biopsychosocial model and Zubin and Spring's (1977) vulnerability-stress model. Both of them recognised the influence of genetic and environmental factors of the origin of mental illness; both of them can be

accommodated according to each psychiatrist's orientation. Expressed emotion could maintain such an ambiguity very smoothly.

Finally, there were another couple of key factors: using expressed emotion it was possible to design research studies that used a simple methodology to investigate families. If we divided families in 'high' and 'low' expressed emotion families, it was then extremely easy to investigate the influence of the family factor on relapse rates. Using the same four-entrance tables used in medication studies avoided the complexities and subtleties often necessary with other, more sophisticated family measures (see Wynne, 1988). Second, and even more important, it was possible to use the expressed emotion factor to design family interventions and verify the outcome of such intervention. Expressed emotion gave psychiatry a set of simple guidelines to work with families and to assess the results of such a work (see Leff, 1989).

Thus I began working with expressed emotion, at first simply trying to prove its relevance for an Italian population (Bertrando et al., 1992), then trying to use it as a guide for practising with families. At this point, I realised that all my years as a student and then as a trainee in psychiatry had done next to nothing for preparing me to face families. I remembered a volume I had found some years before at a second-hand bookshop, titled *Verso una teoria della schizofrenia* (*Toward a Theory of Schizophrenia*) (Cancrini, 1977). It contained, of course, the famous paper by the Bateson group (Bateson et al., 1956), together with some others and some Italian commentaries, informed by critical psychiatry. I read it, did not understand it, but became fascinated with it all the same.

I began reading all the books I could find within this new, strange approach, which was at the opposite end of the spectrum, compared to the good common sense of expressed emotion: here everything was brilliant, theoretically sound and totally counterintuitive. I developed some sort of faith in the systemic model as a 'family cure' for schizophrenic symptoms. Among the books, there was of course *Paradox and Counterparadox* (Selvini Palazzoli et al., 1978), and this led me to begin my systemic therapy courses at the Milan Centre with Boscolo and Cecchin (actually, I had looked for Mara Selvini's courses, only to discover that she did not want to run any course).

I thus discovered that the critique of institutions, the questioning of the social and political status quo, the in-depth analysis of diagnostic and therapeutic procedures, had become, through critical psychiatry, landmarks of the Italian systemic approach (Bertrando & Toffanetti, 2000). In a way, there was no contradiction between my early interests and my new commitment to systemic family therapy: there were some roots in common. At that point, my professional life begun to show some bizarre duplicity. Every day I worked in connection with the university psychiatric clinic, and I held a benevolent psychiatric attitude to families, working in a psychoeducational way, which did not challenge in the least the prevailing psychiatric values. Once a week, I went for training to the Milan Centre, where I explored the consequences of Bateson's rethinking psychiatric categories. In short, every week I contradicted myself, which led to a growing sense of uneasiness.

I can say that a good deal of my subsequent career was a quest for solving this basic contradiction. I think now it is time to leave this minimal autobiography and enter some broader considerations.

Problems with Psychiatric Thinking

The fact is contemporary psychiatry is very far from systemic thinking. I will now try to enumerate the main points of controversy, which will then enable me to focus on options for survival. I think it is important for a systemic therapist to survive within the psychiatric system, that we should be able to stay in psychiatry without necessarily being subjected to its prevailing values. This implies we have to first understand the values (to us, the problems) of present-day psychiatric thinking.

Problem 1: Biology

Many people say that problems began, for systemic therapy, when the 'biological revolution' changed psychiatry (Bertrando & Toffanetti, 2000). Possibly, it was not biology in itself, but rather its use within psychiatry. I maintain that biological psychiatry has been mostly organised around some tacit principles that I like to call dogmas.

Dogmas of Biological Psychiatry

Dogma 1: All psychiatric problems are biological (the ones that still are not, will become biological; the others are not of psychiatric interest).

Dogma 2: Biological disturbances have nothing to do with (human) relationships.

Dogma 3: The influence of biology to psychology and relationship is one-directional: the root is biological, all the rest is an epiphenomenon.

Dogma 4: Biological disturbances can be treated only by biological means. Other means are ancillary, and should be used only after implementing a biological treatment (from Bertrando, 2001, modified).

What is relevant here is not biology in itself (and in relation to psychiatry), but rather the value we attach to it. The idea that psychiatric disorders are biological is, after all, a truism, but it acquires a different value if we read it together with the other dogmas. Dogma 2 states that what is biological is not relational. When in 1980 it was triumphantly proclaimed that schizophrenia (just to name one disorder) was a biologically induced illness, what was said was not that schizophrenia is an event about biological beings (ourselves), and therefore subjected to the laws of biology; rather it was meant that schizophrenia is an entity contained within the organism (in its genome, or in dysfunctions due to events like a viral infection, or perinatal asphyxia, or the similar), without any relationship to the realm of human interaction, story, or meaning. A 'disorder' where the dysfunction is innate, anatomical and as such impossible to repair.

Moreover, in such a view nature is organised in a hierarchy where influences are strictly one-way, from biology to behaviour. The fact is, present-day genetics simply hold that genes determine a *predisposition* (Rose, 1998), whereas biological psychia-

try reasons mostly as if they directly determined behaviour. Actually, the expression of genes is linked to the gene/environment interaction and for humans the environment is primarily a relational one, where all behaviour (including what is called pathological behaviour) has to be learned (see, e.g., Fonagy et al., 2004). To go back to a familiar example of popular genetics, probably the very high rate of musicians in the Bach family was due to genetic reasons; all the same, in order for them to become musicians, somebody must have taught them how to play.

The most dangerous dogma, anyway, is the fourth, which is embodied in most literature about the so-called 'psychosocial' interventions for psychiatric disorders (apparently, the definition of 'family intervention' is outmoded, not to mention 'family therapy' or 'psychotherapy'). For example, if we read the *Schizophrenia Bulletin*, we can see that psychosocial intervention is considered as something that can be put at work only after a 'proper' (i.e., pharmacological) treatment has been implemented (Fenton & Schooler, 2000). If causes are to be found in somatic hardware rather than in relational software, it is obvious to use as a remedy a pharmacological screwdriver rather than words.

Problem 2: Diagnosis

Another key issue in psychiatry today is the emphasis on diagnosis. Of course, such an emphasis is a consequence of the medical nature — recently revived — of psychiatry itself. But this is not the whole story. As Foucault (1999) pointed out, two different kinds of norms interact and often merge in psychiatry: norm as a deviation from physiology into pathology (a medical norm) and norm as deviation from the rules of correct behaviour (a social norm). Thus, the person with a psychiatric diagnosis is, at the same time, a social and a medical deviant, or more accurately she shifts from one position to the other, according to the moment, the institutions involved and their requirements.

The operationalisation of diagnostic procedures, brought forth by DSM since 1980 (see Kutchins & Kirk, 1997), on the other hand, gave to psychiatric diagnosis a new status. Until then, diagnosis in psychiatry had been based mostly on 'clinical intuition' (whatever this may mean) and on the condition of clinical encounter. It is now founded on the application of reliable methods, possibly with the use of standardised interviews, such as SCID (Structured Clinical Interview for DSM IV; First et al., 1997) and the like. Of course, a higher reliability is extremely useful in psychiatry (at least, we all know what we are talking about when we use the same category). The problem is reliability is taken to mean validity, which it is not, and thus it gives diagnoses an aura of objectivity they do not have. The alliance with biological psychiatry strengthens such an aura even further.

This would not be that important, if psychiatric categories did not share with other human classifications a feature noticed by Ian Hacking (1995) when he speaks of the 'looping effect of human kinds: A difference between natural sciences and social sciences lies in that the classification in natural sciences uses indifferent categories, whereas the classification in social sciences uses interactive categories' (p. 108). This implies that when I call, for example, 'Plutonium'

Plutonium, this does not make any difference for Plutonium, despite all its dangerousness. On the other hand, calling a person 'schizophrenic' makes a lot of difference for that person and her family. This idea of diagnostic labelling is an old concept in the Milan school that created the premises for its strong diffidence toward diagnosis.

Problem 3: Family and Family Treatment

What we could call following Ronald Laing (1969) a 'politics of the family' is still a key issue for the relationship between systemic and psychiatric thinking. The most frequent objections to early systemic etiogenetic theory of mental disorders are that they are guilt-inducing (Anderson, 1986). Of course, guilt inducement sometimes happened, and some early theories actually blame parents — although it is bizarre that the most guilt-inducing of all, the 'schizophrenogenic mother' theory, was created by Frieda Fromm-Reichmann (1948), a psychoanalyst who never did one session of family therapy. Possibly, the issue of guilt was brought forth by the intersection begun in the mid-1960s between systemic family therapy and antipsychiatry, with its concept of 'family mystification' (see Laing & Esterson, 1964). One consequence of such misunderstandings is that some treatment guidelines, such as the PORT guidelines, recommend family treatment in the case of schizophrenia, but only with methods different to family therapy, which is considered as inherently guilt-inducing (Lehman, Steinwachs, & PORT Co-investigators, 1998).

This led to psychoeducation, with its emphasis on the concept of illness, which developed in a very medical way. The ill person is somebody who has lost her flexibility and ability to adapt herself to the environment. After all, the basic rehabilitative idea for chronic illness is to educate the person to live following more restricted and limited rules. Accordingly, psychoeducation educates the family (the patient's proximal environment) to become less demanding and conflictive, as if to say that a normal family cannot be appropriate for a mentally ill person, and therefore it must become slightly 'abnormal' in order to accommodate her (McFarlane, 1991).

I am not against psychoeducation as I practised it in the past and still do so when necessary. There are some lessons to be learned from psychoeducation (and I will deal with them further on) but also some shortcomings, in particular the risk of polarisation. When some relevant personalities in the field of psychoeducation say: 'We are here to help the family to help the patient', they are dividing the family in two, the sane on one side, the ill on the other. Such polarisation goes against the unity of the family, and may have rather serious side effects.

Problem 4: Technologies of the Self

I have argued elsewhere (Bertrando, 2007, Chapter 10) that any kind of psychological or psychiatric technique may define what Michel Foucault (1988) called a technology of the self, that is, a set of practices that leads to a redefining of the person's self. Foucault's definition implies that, if I engage continuously in practices aimed at some modification of myself, I end up applying to myself a complete self-discipline and, in turn, such a discipline will modify my own way of experiencing and perceiving myself: I

will become a different person. Or, better, my being and becoming a person is (also) due to the various technologies of the self I applied to myself through the years.

Of course, psychotherapy is a relevant example of a technology of the self; but also other kinds of treatment may have the same consequences on the persons that make use of them. Let us compare, in this respect, what we can call 'classical' systemic family therapy to today's standard psychiatric drug therapy, informed by the ideology (the dogmas) of biological psychiatry. What kind of person do they produce? We can define her by approximation.

First of all, the person produced (favoured, shaped) by the psychiatric technology of the self, considers herself as an ill person. This does not simply happen because this person asks for (and usually obtains) her share of medication. It is something deeper: under the pressure of biopsychiatric dogmas, the person does not think that problems have something to do with her human environment. Her problem is an illness, an illness that is biological, structural and mostly chronic. It cannot be eliminated, only controlled by the right medication, without further hope, except the hope fostered by the progress of future research and so on. Of course, this is not the destiny of all undergoing pharmacological treatment; it is only the destiny of somebody subjected to biopsychiatric ideology.

On the other hand, acceptance of biopsychiatric dogmas has its rewards. The most important is being freed by any problem of choice. Any psychogenetic theory of psychiatric problems implies at least the possibility of blaming ourselves for them, because another choice is always possible. A biogenetic theory implies that something is not working within the person's body, her hardware, which nobody can choose. At the same time, the other, nondiagnosed family members become 'sane' by necessity. Following what we can consider as a law of human relationships (at least within a systemic view), the more somebody is ill, the more someone else is sane.

Instead, what is the kind of person produced by classical systemic therapies? She was not considered ill, to the extent of being an 'identified patient' because of biology, but a client by virtue of her position within a relational network. All obstacles to her self-realisation were external and the main therapeutic goal was to remove them. After that, the person (and other family members with her) could be considered free. The person favoured by such technology of the self was a kind of embodiment of the hero in the American myth, the self-made person, within a therapeutic vision that Roy Schafer (1976) could well define as 'comical'.

With this attitude, systemic practices gave to psychiatry and psychotherapy an optimism that was until then unknown, but also caused some problems. In psychiatry, where disorders were most severe, systemic therapies not only did not reach the results they had promised, but sometimes produced a deep disillusion for patients, families and, in the end, therapists. In time, it became clear that, despite any 'liberating' intervention (change of patterns, alliances, premises, and later narratives, conversations, linguistic systems and so on), psychiatric symptoms and associated problems simply did not disappear, and patients sometimes broke down, in other instances adapted to a grey condition, with little hope of a better life. Thus, if the biopsychiatric technology of the self is hardly justified, the classic systemic one is not much better.

Options for Survival

The situation I depict for systemic therapists in psychiatry seems, at this point, rather gloomy. No wonder fewer and fewer of us want to stay in psychiatry and, if we do, the tendency is to forget our systemic origins. Actually, it is gloomy only if we insist on fighting the prevailing ideology, instead of imagining options for survival. Here I will try to outline a few of them. Of course, to some extent they worked for me, which does not mean they will work for everybody in any situation. They are not meant as a kind of guide to survival, but rather as suggestions, ideas that anybody can develop as she pleases, accept, abandon, or overlook, depending on her actual work context.

Option 1: Biology as Relationship

The ideology of biopsychiatry has been useful, like any ideology, to make a difference and define new standards. It becomes a straitjacket if it is considered, as is apparently happening, as a set of indisputable dogmas. Introducing a biological perspective could help to reach a better balance in the systemic vision, provided that we do not introduce the biology advocated by biopsychiatrists, but rather a different one: a dynamic, plastic, flexible one (Rose, 1998). Such a biology exists and is proposed by behavioural genetics, which studies the interaction between genome and human environment, and is researched mostly in families (see for example Reiss et al., 2000; for research on schizophrenia, see Tienari et al., 1987). It is the one resulting from research on mirror neurons, which indicates that brains, even before minds, show a relational structure (see Iacoboni et al., 2005; Rizzolatti, 2005).

The distinction I want to draw is between what I call ontological and methodological biology.[1] The first sees the biological explanation of interactions as more realistic and objective than any other, 'the really real ones'. Methodological biology sees biological interpretations as scientific hypotheses, which can be falsified by other hypotheses at any moment (Popper, 1959). One point of view can be more valid than another, but it is always subjected to critical analysis.

This kind of biology could help systemic therapists to consider a person as a biological entity in interchange with her (human and material) environment, rather than a *tabula rasa* shaped by relationship. This favours a deeper awareness of what Schafer (1976) used to define the 'tragic' in therapy. The therapist helps her patients to be aware of her own and others' limits and contextual restraints. Such awareness would also help her to more realistically see possibilities for change and self-determination, avoiding both rigid determinism and illusory solutions.

To go back to technologies of the self, the kind of person produced by methodological biology will be aware both of restraints *and* possibilities. She will know for sure that she is subjected to limits she cannot trespass, but, at the same time, she would never be resigned to lead a deficit-based existence. She will, if this idea is not too utopian, get some ideas about how circumstances and context modify her way of being, and of the extent to which she may or not modify such contexts. She could, even when she faces her limits, find the context that is more of a fit for her.

Option 2: Diagnosis as Hypothesis

It is not possible (nor even advisable) for systemic therapists to challenge present-day diagnostic systems, with all their task forces and inextricable statistic procedures (although the results are sometimes far from satisfactory). What we can do, instead, is to challenge psychiatry about the use of diagnosis: what happens when psychiatric diagnoses cease to be pure abstract entities and begin to operate in persons' lives. Here we have something to say.

The person, first of all, is always more than the sum of her diagnoses. Here the lesson of narrative approaches to therapy is seminal: the search for unique outcomes (White & Epston, 1990) aims precisely at going beyond the label. Moreover, no diagnosis can be final. Any diagnosis (which I think is best seen as the snapshot of a present situation, rather than a life sentence) can be reconsidered at any time. Psychiatric diagnosis thus becomes both limited and temporary.

All this, trivial as it may seem, stems from a simple consideration: any diagnosis is like a map. According to the aphorism by Alfred Korzybski, famously quoted by Bateson (1970), 'the map is not the territory' — 'a diagnosis is not a person'. If we keep this in mind, we can use diagnoses, which are after all sometimes good enough maps, in a useful way. Otherwise, we will fall in the error of the cartographers imagined by Argentinean writer Jorge Luis Borges (1946):

> In time … the Cartographers Guild drew a Map of the Empire whose size was that of the Empire, coinciding point for point with it. The following Generations, who were not so fond of the Study of Cartography saw the vast Map to be Useless and permitted it to decay and fray under the Sun and winters. … In the Deserts of the West, still today, there are Tattered Ruins of the Map, inhabited by Animals and Beggars; and in all the Land there is no other Relic of the Disciplines of Geography. (p. 86)

Option 3: Family Intervention as Politics

As I observed before, possibly the most severe misunderstandings surrounding systemic therapies came from their application to families of persons diagnosed with psychiatric disorders, notably schizophrenia, although I think the gap between such families and systemic therapists is not as deep as often suggested. What I try to do is to connote family intervention in psychiatry as a political enterprise.

What working with relatives of schizophrenics has taught me is consideration for the burden of care, as well as the stigmatisation and isolation these families frequently find in society. This has led me to adopt a more supportive stance towards relatives. Of course, such an understanding does not mean I underestimate the suffering and the disruptive experience that life holds for a person with severe mental disorders. In this regard, I try to develop equal empathy toward all family members.

Another important psychoeducational achievement lies in giving (all) family members some idea of what we know, as (presumed) experts, about psychiatric disorders. The stance I adopt, though, is somewhat different from standard psychoeducation (McFarlane, 1991). I tend within a diathesis–stress model, to give the highest importance to stress and psychosocial variables, lightening the emphasis on biological variables.

I also try to link the patient to the logic of the sane, by accepting her way of framing the world, at the same time challenging it with my own logic. I also try to show the 'sane' members that the patient's actions and statements have some sense for her (and within the relationship), trying to foster in the family a sense of confidence in one another. To this purpose, it is essential for the therapist to communicate that all family members are equal, and no one is advantaged. A good deal of empathy is required in this phase, together with a language that should be as positive and de-pathologising as possible.

Family, though, is not the only significant system or social network related to psychiatric disorders; many others are involved: school, work, peer group, social, legal and psychiatric services. Another key element of the politics of the family in psychiatry is the consideration of such networks and systems, through a macrosystemic analysis; to put the family in its contextual background and to find multiple access points to the patient's situation. I try to hold an 'integrative' attitude, where I do not mean a total flattening of all approaches into one indistinct approach, but rather a respect for colleagues of different orientation, at the same time maintaining my own position.

Option 4: Treatment as Proposal

As Ronald Laing (1969) put it: 'We hope family practitioners realize, and often they do, that "purely" medical decisions have massive reverberations in a whole network of people, with consequences to many others than the patient alone' (p. 19). Such a position implies that any kind of treatment, from medication to the most sophisticated psychotherapies, has consequences for the whole network, rather than patients alone. My choice of treatment thus has a whole array of implications. This means I consider treatment as a proposal, which I pursue through trial and error, trying to find a consensus between me and the person I am working with. Of course, if and when I obtain consensus, I then have to work in order to get consensus also from other persons, systems and institutions involved. Psychiatric treatment is a political statement, like family work.

Option 5: Acceptance as Survival

As early as 1967, a long-sighted Franco Basaglia (1967) alerted psychiatric professionals against the risk of shifting from the 'bad patient (to be locked in) to the "good" patient (the victim)' (p. 7). He was aware that it was very easy to begin what Carol Anderson (1986) named 'the all-too-short trip from positive to negative connotation' and vice versa: to consider psychiatric patients as persons to 'save' from a malignant society, or even from malignant parents. Bateson himself was all but immune from this temptation (see Lipset, 1980).

In order to be able to work effectively in psychiatry I have to accept some features of it I do not particularly like, for example, that it is also social control, and probably cannot be otherwise, given the present social and political conditions. Sometimes social control is necessary for the best interest of patients and other persons involved. As a citizen, when I exert my rights of social criticism, it is one of

my duties to think of ways of going beyond social control. If I work in clinical psychiatry, it is also my duty to an extent, to be a social controller. It is also my responsibility to keep it at a minimum, without at the same time idealising neither 'the sane', nor psychiatric patients. Of course, what I say about social control can be said about any other facet of psychiatric practice.

Option 6: Dialogue as Future

I have stated it elsewhere (Bertrando, 2007): I believe that a dialogic position is one of the central aspects of systemic practice nowadays, in all the different meanings of the term. I think this is even truer if we look at the relationship between systemic therapy and psychiatry. Although systemic theory, at the beginning, explicitly proposed a new model for psychiatry itself, today it is clear that it cannot convert to its ideas a psychiatry that has followed a very different pathway.

One of the possible solutions to bridge this gap lies in dialogue. Specifically one grounded in what Mikhail Bakhtin (1935) called 'heteroglossia', a world of multiple, historically and socially determined, co-present and often irreconcilable discourses. To me, holding a dialogical position means that I do not only accept the differences that I can have in my relationships with clients, but also that I am able to accept broader theoretical differences, holding my position with respect toward others, without at the same time renouncing it.

The contribution of today's systemic thinking to psychiatry could lay in its ability to problematise issues we too easily take for granted, such as the status of psychiatric diagnosis, the issue of chronicity, the position of the therapists in relation to both patients' (and other family members') suffering and institutional requests, the ethics of psychiatric treatments. Here, what a systemic view may bring to the field is not some easy answer, but rather an attitude on constant questioning, an ability to face dilemmas without needing too many certainties.

On the other hand, Murray Bowen used to say that therapists could not call themselves 'family therapists' if they had not experienced the relationship with a family with a member diagnosed with schizophrenia. Probably, what psychiatry can give to systemic therapy is a close contact to an array of human lives and sufferings (and ways of working with them) that is extraneous to most private practice.

So we go back to one of my initial statements: in order to survive within psychiatry, we have to find a way to stay in psychiatry, without necessarily being subjected to the prevailing values of nowadays psychiatry. Although I am no longer engaged in a full-time psychiatric work, I still have frequent contacts with psychiatry, and I have found my way for surviving in it. I hope these considerations may help other colleagues to find their own ones.

Endnote

1 This distinction is modelled after a similar one proposed (regarding a very different topic) by Umberto Eco (1968).

References

Anderson, C.M. (1986). The all-too-short trip from positive to negative connotation. *Journal of Marital and Family Therapy*, *12*, 351–354.

Bakhtin, M.M. (1981). Discourse in the novel. In M. Holquist (Ed.), *The dialogic imagination* (pp. 259–422). Austin, TX: Texas University Press. (Originally work published 1935)

Basaglia, F. (Ed.). (1967). *Che cos'è la psichiatria?* Torino, Italy: Einaudi.

Basaglia, F., & Basaglia Ongaro, F. (Eds.). (1971). *La maggioranza deviante*. Torino, Italy: Einaudi.

Bateson, G., Jackson, D.D., Haley, J., & Weakland, J.H. (1956). Toward a theory of schizophrenia, *Behavioral Science, 1*, 251–264.

Bateson, G. (1972). *Steps to an ecology of mind*. San Francisco: Chandler Publishing Company.

Bertrando P., Beltz J., Bressi C., Clerici M., Farma T., Invernizzi G., & Cazzullo C.L. (1992). Expressed emotion and schizophrenia in Italy. A study of an urban population. *British Journal of Psychiatry*, *161*, 223–229.

Bertrando, P., & Toffanetti, D. (2000). *Storia della terapia familiare. Le persone, le idee.* Milano, Italy: Raffaello Cortina.

Bertrando, P. (2001). La biologia retorica. Discorsi biologici e politiche psichiatriche. *Terapia Familiare*, 66–67, 61–80.

Bertrando, P. (2007). *The dialogical therapist*. London: Karnac Books.

Borges, J.L. (1946). Of exactitude in science. In *A universal history of infamy*. London: Penguin Books.

Brown, G.W. (1985) The discovery of expressed emotion: Induction or deduction? In J.P. Leff & C.E. Vaughn (Eds.), *Expressed emotion in families* (pp. 7–25). London: The Guilford Press.

Cancrini, L. (Ed.). (1977). *Verso una teoria della Schizofrenia*. Torino, Italy: Boringhieri.

Eco, U. (1968). *La struttura assente*. Milano, Italy: Bompiani.

Engel, G.L. (1997). The need for a new medical model: A challenge for biomedicine. *Family Systems Medicine*, 10(3), 317–331. (Originally work published 1977)

Fenton, W.S., & Schooler, R. (2000). Evidence-based psychosocial treatment for schizophrenia, *Schizophrenia Bulletin, 26*(1), 1–3.

First, M.B., Spitzer, R.L., Gibbon, M., & Williams, J.B. (1997). SCID-I. *Structured Clinical Interview for DSM-IV Axis I Disorders*. Washington, DC: American Psychiatric Association.

Fonagy, P., Gergely, G., Jurist, E.J., & Target, M. (2004). *Affect regulation, mentalization, and the development of the self*. London: Karnac.

Foucault, M. (1961). Preface. In *Folie et déraison. Histoire de la folie à l'age classique*. Paris, Plon, pp. I-XI.

Foucault, M. (1988). *Technologies of the self*. In L.H. Martin, H. Gutman, & P.H. Hutton (Eds.), *Technologies of the self. A seminar with Michel Foucault*. Amherst, MA: The University of Massachusetts Press.

Foucault, M. (1999). *Les anormaux. Cours au Collège de France, 1974–1975*. Paris: Gallimard.

Fromm-Reichmann, F. (1948). Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy. *Psychiatry*, *11*, 263–274.

Hacking, I. (1995). *Rewriting the soul. Multiple personality and the science of memory*. New York: Basic Books.

Iacoboni, M., Molnar-Szakacs, I., Gallese, V., Buccino, G., Mazziotta, J.C., & Rizzolatti, G. (2005). Grasping the intentions of others with one's own mirror neuron system. *Public Library of Science, 3,* 529–535.

Kutchins, H., & Kirk, S.A. (1997). *Making us crazy. DSM: The psychiatric bible and the creation of mental disorder.* New York: The Free Press.

Laing, R.D. (1969). *The politics of the family*. London: Tavistock Publications.

Laing, R., & Esterson, A. (1964). *Sanity, madness and the family. Families of schizophrenics*. London: Tavistock Publications.

Leff, J.P. (1989). Controversial issues and growing points in research on relatives expressed emotion. *International Journal of Social Psychiatry*, *35*(2), 133–145.

Leff, J.P., & Vaughn, C.E. (1985). *Expressed emotion in families*. London: The Guilford Press.

Lehman, A.F., Steinwachs, D.M., & PORT Coinvestigators. (1998). At issue: Translating research into practice: The schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin*, *24*(1), 1–10

Lipset, D. (1980). *Gregory Bateson: The legacy of a scientist*. Englewood Cliffs, NJ: Prentice Hall.

McFarlane, W.R. (1991). Family psychoeducational treatments. In A.S Gurman & D.P. Kniskern (Eds.), *Handbook of Family Therapy* (Vol. II). New York: Brunner Mazel.

Popper, K. (1959). *The logic of scientific discovery*. New York: Basic Books.

Reiss, D., Neiderhiser, J.M., Netherington, E.M., & Plomin, R. (2000). *The relationship code: Deciphering genetic and social influences on adolescent development.* Cambridge, MA: Harvard University Press.

Rizzolatti, G. (2005). The mirror neuron system and its function in humans. *Anatomical Embryology, 210*(5–6), 419–21.

Rose, S. (1998). *Lifelines*. London: Penguin Books.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox*. New York: Jason Aronson.

Schafer, R. (1976). *A new language for psychoanalysis*. New Haven, CT: Yale University Press.

Tienari, P., Sorri, A., Lahti, I., Naarala, M., Wahlberg, K.-E., Ronkko, T., Moring, J., & Wynne, L.C. (1987). The Finnish adoptive family study of schizophrenia: Possible joint effects of genetic vulnerability and family interaction. In K. Hahlweg & M. Goldstein (Eds.), *Understanding major mental disorders* (pp. 33–54). New York: Family Process Press.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Wynne, L.C. (Ed.). (1988). *The state of the art in family therapy research: Controversies and recommendations*. New York: Family Process Press.

Zubin, J., & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology*, *86*, 103–126.