

## The Diagnostic and Relational Process in Psychiatry. The Epistemological Validity of Normality and Pathology

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**ABSTRACT.** – This work aims to define the low epistemological relevance of method in psychiatry. We examine issues concerning the therapist-patient relationship; diagnostic labelling; fragmentation of the patient's system of possibilities, and the impossibility of controlling differences between therapists with regard to the subjectivity of therapeutic relationships. Clinical research needs to tackle these questions to find a line of continuity between normality and pathology as there are no common peculiarities traceable only to patients. There is a fluctuation between more adaptive behaviour and more dysfunctional behaviour within both a pathological framework, and so-called normality. The fluctuation is based on the roughly adequate relational structure that characterises these dimensions and marks a *continuum* in the passage between normality and pathology. The structure can weaken to the extent that it turns into pathology. From these observations, we can explain the patient beyond the aspects that are typically circumscribed by mental disorder. This can lead to a more comprehensive view of the patient's possibilities, and therefore, enable a more objective assessment that partially deconstructs the fragmentation process resulting from diagnostic labelling.

*Key words:* Labelling; fragmentation; subjective judgment; method; relationship; clinical research.

### Introduction

Diagnoses enable us to observe patients according to a particular cognitive system (Migone, 2011). Kagan (1998) interpreted this system as a partial diagnostic classification sufficient to condition therapy. Laing (1959), however, focused on preconceived mental categories that influence the therapist-patient relationship. Thus, diagnostic labelling can inhibit what we define as the 'helping relationship' as managed by a psychiatrist.

This relationship differs from the psychotherapeutic approach in the

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event of a psychiatrist *also* being a psychotherapist. Therefore, the relational issues of psychotherapy (see Allò, 2014, 2017), and the ethical issues associated with the relational characteristics of the therapist-patient relationship (Corradini, Crema, Lupo, & Saviane Kaneklin, 2011) are not discussed here. We focus on the helping relationship as distinct from aspects concerning the exploration of a specific form of intervention. A line of enquiry leading to a definition of the relationship between patient (client) and therapist (Carli, 1993; Carli & Paniccia, 2003) is not discussed here.

Whether or not we use the psychotherapeutic approach, or a schema for a specific clinical intervention, in psychiatry a helping relationship may be instituted that must be analysed. We identify a diagnostic procedure to counter the relational approach, that has potentially useful implications for clinical research.

### Validity of the method

Sciacchitano (2013) drew attention to the epistemological weakness of psychiatry which only outwardly has the 'rigour' of medicine, creating an unacceptable dividing line in what should be 'science'. Thus, a thin margin is established between the rules of the method and what the object of study might be beyond these rules, in the discrepancies of the method.

Naturally, we need a perfectible concept of 'science', or at least a *decidable* one, for observations (limited) which allow for alternatives for varying (or abandoning) the method, and *deciding* the validity of a working hypothesis, with a view to its modification. Our criticism is not aimed at the possibility of making diagnoses, but at evaluation parameters that *are more limited than they should be*, thereby making it difficult to *optimize* the method. We find epistemic prejudice in the lack of valid control over the object of study, through working hypotheses that are liable to be optimized in the definition of the method.

We should point out that the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) does not deal with single individuals, but with a set of individuals, presenting statistics for homogeneous groups of the population, adopting a range of *technological* interventions in the interests of drug therapies and insurance companies (Sciacchitano, 2013). Further, if it is true that a diagnosis can vary depending on the currents in psychotherapy (Migone, 2011), it is also true that patient fragmentation already occurs in the most important diagnostic systems. The latter are analysed by Migone (2011), the DSM-5 (American Psychiatric Association [APA], 2013), the ICD-10 - International Classification of Psychic Disorders (World Health Organization, 1992) - or the Psychodynamic Diagnostic Manual (PDM Task Force, 2006).

In considering the problems shared by the major reference manuals, Sciacchitano (2013, p. 250) interprets the PDM as a 'tired imitation' of the DSM, since psychoanalysis is not based on a justified causal link between what one *would like* at an unconscious level and what is *described* by the symptom. Naturally, every diagnostic system aims to observe a part of 'reality' (Migone, 2011), but note that categorisation is already limited in its premises (as a working hypothesis *more limited than necessary*), and given to fragmenting the patient in its descriptions (diagnoses that consider an excessively limited fragment of the patient), in its inability to re-define (reassemble) the patient more comprehensively. Observations that stop at individual behavioural elements are unable to 'rebuild themselves' to reach a higher level of analysis. This does not just apply to the weak comparison between viewpoints of different systems, but since each system is already defined in the rules that circumscribe it, to the inability to produce a more respectful profile of the patient notwithstanding the diagnostic label. The 'alleged stability and coherence of diagnostic systems is (...) a crime of pride in that it scotomizes fluidity, conceals doubt, asserts certainty' (Saraceno & Gallio, 2013, p. 27).

Of course, the above limits do not rule out reliability in the diagnostic concordance of different psychiatrists concerning the same patients even in the event the diagnostic process were repeated. The problem is that the diagnosis can be repeatedly wrong (Migone, 2013). In effect, the DSM increased its «reliability which had previously been extremely low but did not (...) modify the validity of the diagnoses, which remain simply conventional» (Migone, 2013, p. 572). A patient can be 'deciphered' simultaneously using different diagnoses (Migone, 2013). Besides, in admitting working hypotheses that are more limited than they should be, it is clear that although «using so-called scientific rigour (...) psychiatrists would be unable to distinguish a disorder from normal suffering» (Migone, 2013, p. 579). It is true that the DSM-5 has introduced dimensions which help us observe the quantitative modifications of patients (personality, cognition, humour...), *drawing pathology closer* to so-called 'normality', without neglecting the standpoint (theoretical and methodological) which identifies with the description of pathology and not in the definition of causes which could break the pathology down into its constitutive elements (Migone, 2013). If DSM-5, like the former editions, presents this incapacity, it would be better for DSM-IV-R 'to stop there, and block the implicit (and explicit) logic of the method (...) because at that point an extra paragraph would suffice to expose the inadequacy of its epistemology' (Galli, 2014, p. 568).

A problem arises in thinking that the (inadequate) progression of the DSMs is due to the (inadequate) rules which generally define the psychiatric approach today (Di Vittorio, 2013). Unsurprisingly 'if two clinicians use different instruments (...) they can reach different conclusions» (Cornoldi, 2007, p. 79).

It is opportune here to emphasize that according to the current paradigm the ‘scholar (...) stops investigating, exploring, trying to understand the complex system that underlies normal and pathological psychic manifestations, renounces experiencing a therapeutic relationship with the other, avoids the work of self-reflection’, thus ‘becoming (...) practitioners alienated from the relational system in which they are inevitably involved’ (Iorio & Iorio, 2016, p. 64). The important thing is to extract the diagnosis from a description of observed symptoms. For the therapist, this means using the deficient automatism of the (inadequately) pre-constituted information of reference manuals (Iorio & Iorio, 2016). Besides, these questions come within a ‘biological reductionism (...) camouflaged in the guise of modern science. It is almost like a farewell to psychopathology (...) to the therapeutic relationship’ (Iorio & Iorio, 2016, p. 67). We do not ‘deny the importance of biological research in psychiatry, what we want is to challenge the distorted epistemology that supports it’ (*Ibid.*). In short, the messiness of the (extremely limited) union between ‘biological’ and ‘psychic’ concepts is transferred to the level of ‘science’, with lines of demarcation (and identification) that are no so well-defined.

It is no coincidence that we can decipher a diagnosis which imposes an *unjustified* stigma on the patient without an acceptable causal link. Not only that, but we can decipher a diagnosis that leaves patients free to self-impose the stigma based on arbitrarily assumed definitions, no longer exposing their malaise to the therapist, indicating symptoms which *supposedly* match the description of the disease, but rather, exposing (without being fully informed) the label (*believed*) to represent the pathological condition (Iorio & Iorio, 2016) without mediation.

At this point, we should formulate a different question in consideration of the relational system the psychiatrist is involved in. The system may be weakened by the diagnostic structure but it can present its own themes. A diagnosis that imposes weak labelling, inadequately fragmenting the individual with its descriptions, must be supplemented by a *relational* problem. If it is true that the rigid schematism of reference manuals admits inadequate discretionality, *i.e.* inadequate capacity for judgment, it is also true that inadequate discretionality is not ruled out based upon the relational characteristics of individual therapists. These characteristics may be implemented within the semantic field of the diagnosis (and related drug therapy). In practice, aside from the diagnosis (for models that eliminate the relational element), different psychiatrists can act inconsistently towards different patients (or, hypothetically, towards the same patient) based on their *personal* characteristics. The action cannot be regulated by diagnostic models not designed for the purpose. In this sense, we must ask ourselves whether the relational ‘method’ is capable of producing significant objective regularity, thereby controlling an action that is potentially characterised

by the free choice of the psychiatrist. We can define the absence of epistemological validity by asking whether the psychiatrist is in a position to re-check his action based on intersubjectively controllable, replicable, and decidable procedural rules (working hypotheses). A procedural dimension that is hardly small because in the absence of epistemological validity we can offer therapeutic validity and obtain a suitable *relational* result. However, *without epistemological validity the result cannot be validated* by justifying it based on the procedure implemented (it may be replicated in this way by other therapists).

If we support psychiatrists in not neglecting their relationship with patients, for example through unstructured interviews or in sharing a specific life routine, we could argue that they act in the absence of a shared and shareable method, incapable of being decided by subjectively valid rules, therefore unsuitable for controlling the object of study. We have shifted away from the rules of the diagnostic method, unsuitable for a relational procedure, finding rules that are impractical for the purpose, inept at eliminating the (possible and *not necessarily suitable*) engrafted differences between therapists. It is clear that if the rules of the method cannot control the (potentially arbitrary) differences between psychiatrists, neither can they be responsible for (adequately) controlling the patient's action, given that such action is attributable to the subjective skills of the psychiatrist. Therefore, the action is attributable to what may prove to be inadequate skills unless one believes that the *personal* skills of psychiatrists are always suited or adaptable to their intended purpose (and to a particular patient).

Inadequate action comes from following the diagnostic method slavishly, and, for that matter, from failing to rule out a (potentially) arbitrary action in the desire for its emancipation, transferring (at least one) part of the therapeutic process to the therapist-patient relationship. In practice, an inadequate process can play out when psychiatrists rely on their empathy, their sensitivity, and their intuition, and make observations unmediated by the working hypotheses of a precise methodology. These observations are non-replicable among therapists since they are based more on personal abilities than on a method to regulate those abilities. Wanting to regulate those abilities does not mean wanting to inhibit them. Allowing regulation means their abilities may be expressed clearly and coherently, even optimizing them according to the rules they should be based on. For this, the rules must be observed in a shared and shareable way. We do not mean to do without the abilities of individual therapists (*e.g.*, in developing empathy), but we do need a method that in controlling the therapist can also be modified by him if necessary to obtain a clearer idea of the rules that govern actions. In short, what we do not want is subjective validation (potentially arbitrary) of the possible overwriting of the method, but a method that allows subjectivity to express itself clearly, and if necessary, violates the rules that the

method imposes (in the event they are clearly defined). To demonstrate the fundamental importance of the relationship, we will show it in its constituent, but not necessarily positive, elements.

The first problem arises in the assignation of simplistic labelling to an individual (Maslow, 1962). For the author, labelling is weakened by the challenge it presents in finding a real patient who corresponds to the pre-established description of the reference manuals. These problems continually arise when trying to explain patients using valid science-based theories. Of course, Laudan (1977) has cast many doubts on the direction of scientific research, finding fault with the (im) possibility of its being *exactly* reconstructed, but the fact remains that conceptual paths in psychiatry are presented in *a more limited way than is necessary*. The psychiatrist acts within a context largely defined in the absence of a cause of illness, and consequently is compelled to make (extremely limited) reference to the DSM or the ICD-10, using the same argument (Wakefield, 2010). In this way, 'the conceptual integrity of diagnostic criteria is still a problem that is tackled in such an unsystematic way that at times it seems that correct diagnoses are left to chance' (Wakefield, 2010, p. 300). Indeed, as Frances (2010a, p. 251) pointed out, it may be that we classify as mental disorder many normal behavioural variants, thereby undermining the very concept of 'mental disorder'. Moreover, concerning the differences between a 'dimensional perspective' and a 'categorical system', the author reiterates that 'our discipline has never reached a consensus on which dimensions to choose and how to measure them' (Frances, 2010a, p. 255). A criticism of DSM-5, that may be found in Spitzer (2011) and Spitzer and Frances (2011).

The second problem arises from a different, but parallel factor: there is 'increasing evidence (...) that good psychiatric practice requires a commitment to the non-technical aspects of our work, for example, to relational aspects' (Bracken *et al.*, 2012, p. 9). Psychiatrists in their 'daily experience' use 'a variety of unconscious and preconscious inductive knowledge, organized in *Gestalt*-like ways, of acting with the patient', defined as 'guidelines dictated by intuition or experience' (Migone, 2015, p. 50). Proceeding in this way, *i.e.*, defining the quality of the relationship between psychiatrists and patients, has proved to be more effective than medical treatment (Migone, 2015). We cannot be limited to a diagnosis that fixes the object of study, dehumanizing the patient (Dell'acqua, 2013). The diagnosis leaves out patient's subjectivity, obliterating it for cultural, political, and economic reasons (Benedice, 2013), all the more so if we consider that mental disorders 'are constructs that we have invented (...) For example (...) there is no prototype of 'schizophrenia' that can be explained using a biological model' (Frances, 2010b, p. 101). It is no coincidence that the descriptive paradigm has failed to delimit a change capable of directing us towards the causes of the disorder (Frances, 2010b) and it is no coincidence

that «psychopathology (...) presents overlap not only in its way of manifesting itself but also in its pathogenesis. There are probably hundreds of pathways leading to schizophrenia' (Frances, 2010b, p. 103). Moreover, 'beyond (...) rare cases of a causal link, genetics has only highlighted rather weak risk factors' (Gonon, 2011, p. 146), admitting the importance of the environment in the development of the disease.

In considering the aforementioned diagnostic limits, and considering the undeniable advantages of a relational approach, how can we define the second problem related to the non-technical aspects of the psychiatrist's work, *i.e.*, the relational system? We can define it by recording a non-valid dimension, a dimension bound by the different approaches that various therapists implement based on personal skills that may not necessarily be adequate. For example, in the course of the relational path, can we control the inductive processes mentioned referable to the non-technical dimensions of the psychiatrist's work? Can we control the (not necessarily adequate) unconscious and preconscious processes used to develop certain intuitions? Can we rule out the possibility that we may be acting incorrectly? Of course, on completing a certain relational path a positive outcome may result, but does that mean excluding that there may be an inability to build a qualitatively profitable relationship? We must ask ourselves whether the patient has been put in a position to act out that responsibility (see Beck, 1976; Beck, Rush, Shaw, & Emery, 1979; Rogers, 1942), and at the same time ask ourselves whether the real responsibility - autonomy - of the patient in relation to the therapist can be delimited. This in the production of feeble therapist-patient rules. If the delimitation of the patient becomes personal, how do we define the type of freedom and responsibility that the therapist can *pass on* (or not) to the patient? Of course, the responsibility may prove to be adequate, but it would always be about the psychiatrist's abilities, thereby *increasing* the chances that the psychiatrist may *also* prove to be inadequate. In psychiatry, the inferential process *seems* not to allow violation of certain rules - the actions being pre-determined by diagnostic schema- but violation arises when the unknown element - the psychiatrist's *personal* choices - is introduced. Therefore, methodologically unjustified changes in any method must be diagnostic (in the inability to regulate the relational characteristics of the therapist), or the admission of a (supposed) relational method (based on the personal rules of the Psychiatrist's possibility system).

### Schematization of the reasoning

If a schema defines which information needs to be delimited to measure certain effects (symptoms), we encounter the problem of reducing diverse phenomena to a diagnostic label (Jaspers, 1959). A description of the disorder

der cannot be a complete picture of the individual as a whole (Jaspers, 1959). For this reason, a more inclusive level of analysis which takes account of the individual's possibilities is essential; the need to consider that 'in principle, the name of a medical condition is not of vital importance' (Freud, 1911, p. 511). The diagnosis should be seen as a theory that is subject to empirical evidence, in need of possible reformulation (Beck *et al.*, 1979). A diagnostic schema should define a provisional schematization (Jaspers, 1959). The concept of schema implies boundaries, boundaries that are not accurately delimitable. If we are unable to set boundaries, in theory, we cannot talk in terms of a schema, or rather, we can talk in those terms, but we cannot expect to prove that it is, not if we think that in doing so we can refer an action back to the schema we wish to implement (Marsonet, 1997). We must not give room to the rigid forms that Kant (1787) instituted to categorize reality. The individual does nothing but act on theories - presenting a certain *belief* - and this is binding (Feyerabend, 1975; Putnam, 1990). Asking ourselves whether 'there is a reality of things capable of determining which conceptual schema, among those that are so useful to us' that can be 'really true' (Putnam, 1990, p. 229), poses an insoluble question. It is our duty to find alternative actions able to optimize a certain level of 'truth'. If our approach to the situation determines our subsequent choices (Laing, 1959), we should vary the premises on which we act, in the rules designed to control our choices. In our case, it is the need to find a stimulus to vary diagnostic schemas.

At this point, we must keep in mind Sullivan's argument (1953, p. 342), namely that there are no such things as 'characteristics which are only apparent in the sick', adding that 'the only differences (...) in degree, *i.e.*, in the intensity and duration of what is common to everyone'. It should be noted that, in everyday relationships, we observe a fluctuation between more adaptive and more dysfunctional behaviour, both within a pathological framework and in so-called normality, with the presence of behavioural discrepancies which are *potentially* more relevant to pathology. In other words, a more significant fluctuation may occur in a mental disorder, with grades of behaviour being more accentuated in the difference between an adaptive and a dysfunctional pole.

We can consider this fluctuation as a *continuum* within normality or within disease, unable to assume any clear demarcation between perfectly adaptive or dysfunctional behaviour, or unable to decide at what precise moment, and on what basis (exact suppositions), behaviour can change from adaptive to dysfunctional or *vice versa*. This behaviour is termed *mainly* adaptive or *mainly* dysfunctional.

We can assume that dysfunctional behaviour in the sphere of normality that goes beyond a certain threshold becomes pathological, while the adaptive one, belonging to the sphere of disease, becomes normality, confirming a further *continuum*, a continuity of different levels. The *continuum* presents



episodic dynamics where the individual may momentarily enter the pathological sphere or the sphere of normality.

The continuity to be examined is based on a (more or less adequate) relational system characteristic of both dimensions. It is a system where the transition between normality and pathology is preserved by limiting its behaviour to a pole of shared and shareable meanings, thus determining individuals' potential to distance themselves from certain social conventions.

Personal discrepancy, fluctuating between positive and negative stimuli (of normality or pathology) is accompanied by social discrepancy (in its capacity to move away, to develop into pathology from a shareable semantic substrate). This is a dynamic typically based on relational characteristics that define more or less adequate behaviour, and thereby individuals, by defining the ability to recognise themselves and be recognised through certain social norms. Naturally, necessarily perfectible norms, which are suitable for defining what is socially acceptable behaviour to gain proper social recognition based on positive and useful personal relations.

A *line of continuity* positioned between normality and pathology stimulates a reflection on what often seems to be the (failed) possibility of justifying the patient beyond aspects imposed by the category - the syndrome. It defines a more comprehensive vision of the patient's possibilities since the mechanism can be applied across different pathologies. Moreover, it is common to different diagnostic schemas, thus achieving a *more objective* level of analysis - with significant epistemological validity - in its capacity to explain the individual beyond symptoms associated with different pathologies. The tendency to adhere to the connection: 'identified effect → definition of disease', makes it difficult to recognise fluctuations in the patient's behaviour within the clinical picture. In other words, behaviour can sometimes turn out to be more positive, and other times more negative, under the influence of particular *relationships*, to the extent that they define the situation experienced. The possibility that behaviour can be independent of its rigid labelling, allows a partial *de-construction* of the fragmentation of diagnostic labelling. If alternation (or fluctuation) is admissible, we cannot preclude a definition of the mental disorder which is *not* centred on the symptoms, nor on the limits set by its categorization, but centred on how much the patient can act regardless of its categorization. Basically, we attach importance to behaviour that can change regardless of the meanings given to the symptoms in the *description*, and break away from the meanings which confirm the symptom. Behaviour which is bound to meanings that are allocated *despite* the symptom enables a deciphering of the individual beyond the *seemingly* defined limits of the disorder and is therefore not (completely) ruled by it. At the same time, pathways are created leading to norms which, partially at least, appear to differ from the ones which regulate the disorder.

The action presents an important premise, requiring us to ask ourselves not what the symptom means, but *what relationships allow, how to evaluate them and how to stimulate them* to inhibit the disease, and even possibly, the rationale adduced. Besides, it is in the space created between the expectation of the symptom, and how much, in concrete terms, the patient can act, that the opportunity for freedom to loosen certain constraints lies. The action would need theoretical and methodological justification; for example, an evaluation of the degradation of social relations, the degrading of the prospects for utilitarian recognition. A dimensional form for observing the quantitative gradations of patients' behaviour may be constituted by a scale to assess the *dimension* of positive and negative behaviour through interviews, questionnaires, or tests (and/or ecological observation). In practice, the discrepancy between a positive (adaptive) and a negative (dysfunctional) pole could be defined by examining the cognitive dimension and/or mood in their capacity to be stimulated by positive relationships or in tackling negative relationships, observing the effects of the concretization of the action experienced in relation to a shared semantic substrate. This applies to situations constructed and perceived as more or less intrusive, more or less stressful, more or less involving, and defining an action that encompasses the gradations tending towards one of the poles.

A dimension that can bridge the gap between pathology and normality, in what the patient often sees as a significant capacity for judgment in discerning positive, useful, and sometimes even opportunistic opportunities. The dynamic is too often hidden behind meanings that macroscopically characterise particularly stigmatizing conditions. Precisely for this reason, we can envision the '*desire for disease*' mentioned by Jaspers (1959, p. 4) where the 'sick want to be pitied, (...) escape the obligation to work, get a pension'. That the patient's will is not as deconstructed as is often thought cannot be taken for granted, thereby acknowledging the possibility that pathological behaviour may fluctuate within the disorder and the importance of relational aspects. Besides, noting these aspects does not imply underestimating the severity of the disease; it is the meanings defining certain relationships that allow it to forcefully re-emerge.

Thus, a specific clinical picture, represented on a Cartesian plane, shows a variable, irregular behavioural curve. The negative values of the symptoms of disease, intensifying in pathological behaviour (in progressive and potential gradations), are represented on the ordinate axis (y-axis), while, in the opposite direction, the positive values determined by the remission of symptoms are represented (in progressive and potential gradations) showing adaptive, more functional behaviour. On the abscissa axis (x-axis), on the other hand, our observation of the subject is represented in a time  $t$ . The succession of possible events is assessed in relation to the subjects' perception of positive or negative stimuli, which may affect the symptoms of the

disease. In practice, we can assess the value of relationships by measuring the remission or the intensification of symptoms (y-axis) in time  $t$  (x-axis). On certain levels, with values determined by the type of perceived and acted relationship, we can display more receptive behaviour, even deliberating a reaction to some meanings, and with them taking form momentarily. This is possible if the subject's environmental influences are positive (unlike the meanings attributable to the disease) enabling the symptoms to be attenuated with behaviour that fluctuates more towards normality.

In contrast, on different levels, subjects may appear to be more 'free' to follow the rules that the condition imposes (or they believe should impose, subjecting themselves to it). The symptom is present as a dependent variable (dependent on the stimulus or relational event), while the positive or negative stimulus in the chosen relationships is present as the independent variable which can be manipulated by the psychiatrist (in such a way as to affect the dependent variable).

Thus, there could be 'no doubt that he was ill with schizophrenia (...)' The problem was that this fact (...) became, in effect, a conflicting opinion (...): on the one hand, Fabrizio was dangerous (...) condemned to isolation (...) on the other, (...) he could go to the bar for a coffee and have company' (Colucci, 2013, p. 7). Fabrizio was ruled by his mental condition in the perception of staff of the facility who based their perception on the diagnostic schema, a schema which rigidly delimited expected behaviour. On the other hand, Fabrizio could be accompanied out of isolation by a psychiatrist (Colucci) able to see (reason and act) beyond the bounds of the given schematization. This example of a helping relationship, where the therapist accompanies the patient in a simple daily task (entering a bar) is anything but obvious. The possibility is only *apparently* simple. Health personnel deems such a relationship to be neither possible, nor desirable, and yet is a concrete (and desirable) possibility through the construction of mutual trust (*relational and personal*) with a therapist present notwithstanding the diagnostic and psychotherapeutic implications: 'What I was able to do with Fabrizio was to untie him every time I was on duty in the ward, trying to remain next to him, even in silence, a situation that Fabrizio appreciated, never taking his eyes off me' (Colucci, 2013, p. 6). In practice, Colucci created an opportunity for himself, naturally, insofar as the patient's system of possibilities allowed.

Of course, it remains to be seen whether another psychiatrist would have stimulated the patient using the same method of operation (in deciding to act as he did) but, even if this were the case, would he or she necessarily have obtained the same result? Furthermore, how controllable are relational pathways in the immediacy of choices which, notwithstanding Colucci's achievement, could prove to be wrong? We have touched on these issues and will, in part, take them up again. For now, the point is that the contrast-

ing opinion described above in relation to Fabrizio as ‘object’ of his disorder, on the one hand, and on the other ‘subject’, regardless of the stigma of the disorder, does not mean taking as granted a tendentially unchangeable schematization. In fact, ‘the first opinion carried more weight than the second’, making ‘schizophrenia as a peremptory and undebatable argument work’ (Colucci, 2013, p. 7). We could concur with Heisenberg (1984) that in considering a single state of a system we should not lose sight of what the system could represent under a different state. This would mean rediscovering a *continuity of action* - anything but an insignificant achievement and favoured by the relational approach.

### Importance of a valid relational dimension

There is a problem in the painting of ‘a picture characterised by kindness but also by haste, in the wish to ‘rush’ the matter through, interactions determined by the protocols of risk assessment, in which the psychiatrist’s questions reflect a somewhat chilling routine’ (Galeazzi & Curci, 2007, p. 48). A lack of familiarity with relationships is evident, underlining at the same time how certain evolutionary changes, ‘produced by a deep empathic relationship, have a greater chance of remaining stable and effective over time, compared even to the effects of drug therapy alone’ (Disanto, 2009, p. 58). In short, ‘relational therapy’ can be more effective than drug administration (Disanto, 2009). Besides, if a figure of attachment is indispensable to enable an individual to acquire certain answers and a certain trust (Bowlby, 1998) during the course of a lifetime, the value of relationship in psychiatric intervention should not be underestimated. In psychiatry, the pharmacological, and even more importantly the diagnostic dimension should not be at expense of the relational dimension, concealing aspects that should be highlighted. The presence of certain ‘technical’ prerequisites, to circumscribe the role of the psychiatrist, *does not necessarily in itself* delimit the establishment of an adequate helping relationship, due to abilities not strictly speaking attributable to theoretical and methodological knowledge. Not surprisingly, even in psychotherapy, ‘the technique’ can be secondary to ‘the therapeutic relationship’ (Clarkson, 1989, p. 39).

To better reflect on the issues involved in a helping relationship we will transfer the semantic field of teaching, where relationships are foundational, to psychiatry. The reason is that, in both cases, we may operate a relational procedure capable of *training* the individual.

Our first point concerns educators’ professional development. Our task is to find a specific reference model while at the same time being aware that we cannot reduce educational work to a rigidly pre-formed schema (Demetrio, 1990; Tosco, 1993). It is ‘necessary for the educator (...) to get

personally involved on pain of a sterile interpersonal relationship' (AIEJI, 2011, p. 7). The educator, not to be considered the only actor in the educational process, draws attention to the educator-educatee dyad, moving past the asymmetry of common intentionality (Stella, 2002). A relationship, therefore communication, which must be substantiated by enhancing our ability to listen to those who relate their story in verbal or non-verbal language (Disanto, 2009).

At this point, we must ask ourselves how compliant would psychiatrists be to such requests. Would they consider them? Or would they be *out of the habit* of adopting such an approach, if we think of relationship as an average between two extremes (Stella, 2002)? This is in the acting out of an inter-subjective 'truth' which, although connected to a theoretical-clinical model, remains bound to the relational context (Ceruti & Lo Verso, 1998). The 'educational event is above all a *relational* event', it does not 'concern (...) a single subject (...), but (...) involves both poles of the relationship' (Iori, 2000, p. 109). We should 'always begin with the concept of relationship to understand education as a relationship between subjects, and pedagogy as an area of knowledge that studies interaction among subjects within this specific relationship' (*Ibid.*). A relationship, and an educational concept which are connectable to the dynamics of therapy, such as, the acceptance of the other as a means of mutual recognition and influence (Calonghi, 1976). Of course, the psychiatrist may not (want to) assume a 'pedagogical' role, but a relationship still exists, if only in conducting an interview functional to prescribing drug therapy (possibly scaling down or increasing). The relationship, being present, and influencing the patient, possibly beyond its expressed intention, may prove inadequate. The patient may trust the therapist, but if this trust is not suitably 'recognised' the interview will be a weak crutch, ready to vanish in the hours following the psychiatric relationship. This relationship is not 'educational'; it passes the burden of the patient's problems on to drug therapy, unable to bear the responsibility.

We are obviously in the realm of implicit meanings, that is, psychiatrists need not openly disavow the figure of the patient, on the contrary, they can be welcoming and helpful. However, if the end purpose of the interview is drug therapy nothing valid can be co-constructed between the actors involved. It may be that the patient shows momentary satisfaction in binding himself to the (*perfectible*) *therapeutic relationship*, administered by someone the patient considers (or wants to consider ) significant, but finds something lacking once the positive (and momentary) effects of the psychiatric encounter are concluded.

The concept of relationship should not be taken for *granted*. It is no coincidence that 'until the beginning of the twentieth-century pedagogical focus was on the predominance of the teacher role (...) and, when attention began to shift to the learner (...), it continued to be considered in terms of

singularity', that is 'in its psychological or functional characteristics (...), generally leaving the *relational and interactive elements* between teacher and learner in the background' (Iori, 2000, p. 109). It is only 'in more recent years' that 'importance has begun to centre on the learner's interaction with the teacher and pedagogical interests have turned more to the transaction, the relational exchanges that occur in the educational relationship', so that 'understanding education as a *relationship* presupposes the use of new interpretative tools and new hermeneutic categories' (*Ibid*, pp. 109-110). Of course, each 'person 'is-with-others' inevitably existing in a network of relations and relationships' (*Ivi*, p. 110). However, we need to know how to manage a satisfactory relationship: both actors, enabled by meeting each other in a fertile way (Stella, 2002) are involved in defining its end.

Mutual motivation is essential, and to be co-constructed based on the gradual consolidation of previous knowledge. But what knowledge can be derived from a weak relationship? Not by chance does 'meaningful learning' depend 'on the adequacy of previous knowledge' (Novak, 1998, p. 37), for a dialogue that forms the basis of a story to be co-constructed in an 'organized manner on a narrative base' (Bruner, 1990, p. 54). Through the dynamics above, if 'the interest of the teaching profession' is aimed at 'the construction and improvement of personal identity' (Zanniello, 1992, p. 58) can psychiatrists not show an interest in the relational dimension? This dimension naturally starts with their role (the intention of re-forming a positive identity), and, in any event, with their willingness to '*deconstruct* their point of view' (Nicoli, 1994, p. 76) given that 'a large part of the success of a formative action is played out on a '*subjective or relational level*' (*Ibid*, p. 75). Therefore, the deconstruction is based on an observation conceivably free from diagnostic (and pharmacological) schemas.

It is clear that if psychiatrists fail to *form the habit* of delineating a helping relationship, how will they adequately 'support themselves' and support the patient in the scaling down of drug therapy? If individuals are to 'overcome their *status*', it would seem 'pathological, inhuman' (Braido, 1967, p. 63) if this state 'were to last beyond what is strictly necessary'.

How often can the patient feel qualified to assume a role defined by the absence of a relationship? Or defined as such by the lack of mutual knowledge? In other words, how many times can the patient intentionally accentuate or inhibit certain deficiencies? And how many times can the psychiatrist fall into the trap of missing a relationship? How is it possible to educate, *i.e.* lead the patient towards not insignificant possibilities (perhaps 'educating' on the 'causes' for the disorder), if educating presupposes a 'meeting of people' (Bertagna, 1991, p. 216)? If these people remain fixed on a system of values centred more on '*having* than on *being*' (Fromm, 1976), could it not be that patients transfer their action to the possession of the drug? Could it be that with the help of the psychiatrist the patient may

be encouraged not to take responsibility for himself, happy to have an easy-to-apply pre-programmed model? In this case, what formative event could be provided?

Keeping in mind ‘that an interactive effect between extrinsic and intrinsic motivation is more likely’ (De Beni & Moè, 2000, p. 36), it is important ‘in addition to reinforcement (...) to recognise the authority of the person who rewards or punishes, the perception of self-efficacy, the concept of self and all cognitive and emotional processes’ (*Ibid.*). Motivation is, therefore ‘a set of subjective experiences, of intrinsic or extrinsic origin, such as goals, expectations, emotional processes, values, personal interests, attributions’ (*Ibid.*, p. 37). To what extent, are these processes linked to the figure of psychiatrists? What are their expectations? Do psychiatrists take advantage of their authority to motivate the patient to form a relationship? Do they encourage the patient (and themselves) in their intention to seek non-pharmacological recognition? Is it not true that attributions are generally drug centred? Or, centred on an insignificant, quick, rushed relationship, which may be welcoming but is, in any event, based on semantic sharing that may be no more than mere courtesy? If motivation ‘is increasingly considered the fruit of goals, expectations, cognitive elements, and not of external driving forces’ (*Ivi*, p. 44), it is appropriate that even external reinforcement is created and strengthened based on a mutually recognised relationship which sets conditions to ensure that *that particular reinforcement* (and not another) can be implemented. Reinforcement is thus created in a spontaneous and non-artificial way, the consequence of a particular relationship, *i.e.*, of the particular semantic construction of the *personal* possibility systems of agent subjects. It is not by chance that ‘motivation can no longer be considered as if it were only based on mechanistic models, such as reinforcement, but must also refer to constructs in which the role of the subject’s interpretation of the situation is pointed out’ (*Ibid.*, p. 49). But what interpretation can the actors involved make based on what has been expressed so far? If the interpretation is centred on the psychiatrist, will it not refer to fixed, univocal canons of reasoning, pre-established by the major diagnostic manuals? Will this interpretation not in turn influence the patients’ interpretation, causing them to fall into the drug trap? Or, into descriptive and non-etiological schemas? Could it not be the case that expectations are attributable to the method, to the evaluation parameters of a particular theory, a theory which too often comes under the currently accepted paradigm (pharmacological and diagnostic). Therefore, if motivation for the relationship is essential, and if motivation can be ‘improved and modified through appropriate training or stimulation via the environment’ (Moè, 2010, p. 13), we need to ask ourselves what kind of relationships psychiatrists can have in the environment in which they move (based on the current paradigm). If ‘many motivations converge in a system of beliefs that

direct not only behaviour, but also how reality is perceived and interpreted' (*Ivi*, p. 15), our interpretation will refer back to a system of beliefs connected, more or less implicitly, to the diagnostic manuals, and therefore to a schema of reasoning that is defined by these beliefs (based on previous evaluation parameters).

Therefore, we need to clash with the rules that the paradigm imposes, disconfirming motivations, thought processes, beliefs, and explanations. Recognizing that behavioural fluctuation is possible enables us to not trace it back to the presence or absence of drug therapy. The relational process will be relevant by being 'made up of people who believe in the potential of the other (need for relationship)' (Moè, 2010, pp. 171-172). In this way, we can argue that 'reinforcement (...) reinforces and motivates those who give it rather than those who receive it' (*Ibid.*, p. 184). This does not mean that we consider the helping relationship to be a panacea for all ills. Along with the positive aspects, we need to point out the negative aspects. If the personal identity of those who conduct a helping relationship contributes the basis of their professionalism (Stella, 2002); if an important component is empathy, based on the ability to recognise the emotions and feelings of others, and understand different points of view (Disanto, 2009); if psychiatrists can use combine their competence and knowledge with their sensitivity in making on-the-spot decisions concerning whether procedural competence can merge with purely personal characteristics, with a substratum of values, or a specific personality, at this point the unknowns make it difficult to 'objectify' the relational task with a variety of psychiatrists (and a variety of educators), even with the same (hypothetical) patient. If the particular characteristics of a psychiatrist prove essential for the harmonious development of the relationship, if a psychiatrist needs to indicate to himself and others not only macroscopic characteristics but also the most minimal of meanings of the situation experienced, and if all this proves indispensable for the construction of a meaningful relationship, it is not simply 'technical' knowledge that proves to be relevant; what is (probably more) relevant is the *subjective* quality which is more challenging to evaluate. In the constitutive processes, the latter quality may not easily be subject to the control required for regulation of the helping relationship which would allow 'objective' scrutiny, and enable the creation of potentially replicable situations in their capacity for being intersubjectively controllable.

## Conclusions

The subjects discussed have referred to the invalidity of the method, placing an unjustifiable dividing line between what the patient represents and what is delimited in the diagnostic rules.



At the same time, the lack of validity of the relational ‘method’, defined by the psychiatrist’s *personal* procedural norms, has been shown: norms that define the psychiatrist’s personal reference system, unmediated by adequate theoretical and methodological rules; in short, with the difficulty of making relational proceedings organic, homogeneous, and subject to inter-subjective control.

If the technological paradigm is based on descriptive schemas and a reductive causal relationship, in a fragmentation of the patient detached from an adequate level of analysis (Bracken *et al.*, 2012), we must reaffirm Wakefield’s point (2010) about the need to not focus exclusively on certain symptoms, not regardless of a thorough examination of the patient’s experience, to make the boundaries between normality and pathology less blurred. In short, the psychiatrist should not be content with observations limited to what seems already decided concerning behaviour, or limits of character, thus presenting caricatural elements (Stoppa, 2013). If neuroscience research is profitably shifting towards boundaries that are not yet definable (Bracken *et al.*, 2012), then a paradigm variation would be desirable. We have not neglected ‘the fundamental epistemological issues that are at the heart of our models’, for a ‘technological paradigm’ that has underlined the ‘tendency towards the medicalisation of daily life which in turn is associated with the expansion of the psychotropic drug market’ (Bracken *et al.*, 2012, p. 11). At the same time, we have given adequate visibility to epistemological questions which are *not relevant* to the technological paradigm. Therefore, if, in the first instance, we identified the deficiencies of a method incapable of defining adequate control over the disorder, and therefore over the patient, in the second instance, the shortcomings and the implications of a method centred on relationships with patients were identified, possibly defining inadequate control over the relationship, and again over the patient.

The dynamics may prove important as a means to escape from an increasingly inadequate paradigm. Some research has set at a negligible level the difference between drug therapy (diagnosis-oriented) and placebo, and, the negative consequences that psychotropic drugs can bring in their wake (Bracken *et al.*, 2012). However, we must not simply focus on the diagnostic aspects (and, consequently, on possible pharmacological effects) or, in the desire to escape an unstable paradigm, *on the mere diagnosis/relationship polarity*. We need to focus on questioning the arbitrariness that may be enacted *regardless of* certain polarities, as well as on stimulating clinical research.

## REFERENCES

- AIEJI. (2011). *Le competenze professionali dell'educatore sociale*. Piattaforma concettuale (versione in lingua italiana). International Association of Social Educators, retrieved at: [aieji@anep.it](mailto:aieji@anep.it)
- Allò, A. (2014). Valore epistemologico del colloquio terapeutico. *Epistemologia*, 37(2), 289-302. doi:10.3280/EPIS2014-002008
- Allò, A. (2017). Psicoanalisi: una valutazione dei principi teorici e metodologici. *Rivista di filosofia Neo-Scolastica*, 109(1), 3-33.
- American Psychiatric Association [APA]. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5. Washington D.C.: American Psychiatric Association [trad. it.: *DSM-5. Manuale diagnostico e statistico dei Disturbi Mentali*. Milano: Raffaello Cortina, 2014].
- Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press [trad. it. *Principi di terapia cognitiva*. Roma: Astrolabio-Ubaldini, 1984].
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press [trad. it. *Terapia cognitiva della depressione*. Torino: Bollati Boringhieri, 1987].
- Benedice, R. (2013). Illusioni e violenza della diagnosi psichiatrica. *Aut aut*, 357(1), 187-211.
- Bertagna, G. (1991). Collegialità e individualità nella professione docente. In Acone, G., Agazzi, A., Bertagna, G., Bertoldi, F., Chiosso, G., Garancini, G., Giffoni, E., Serpico Persico, L., & Vico, G. (Eds.), *Dimensioni attuali della professionalità docente*. Brescia: Editrice La Scuola.
- Bowlby, J. (1998). *A secure base*. London: Routledge [trad. it. *Una base sicura*. Milano: Raffaello Cortina, 1989].
- Bracken, P., Thomas, P., Timini, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N., Double, D., Downer, S., Evans, C., Fernando, S., Garland, M., Hopkins, W., Huws, R., Johnson, B., Martindale, B., Middleton, H., Moldavsky, D., Moncrieff, J., Mullins, S., Nelki, J., Pizzo, M., Rodger, J., Smyth, M., Summerfield, D., Wallace, J., Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, 201(6), 430-34. doi:10.1192/bjp.bp.112.109447. [trad. it. Una psichiatria al di là dell'attuale paradigma. *Psicoterapia e Scienze Umane*, XLVII(1), 9-22, 2013. doi:10.3280/PU2013-001002].
- Braido, P. (1967). *Filosofia dell'educazione*. Zürich: PAS-VERLAG.
- Bruner, J. (1992). *Acts of meaning*. Cambridge (Mass.) - London: Harvard University Press [trad. it. *La ricerca del significato*. Torino: Bollati Boringhieri].
- Calonghi, L. (1976). *Valutazione*. Brescia: Editrice La Scuola.
- Carli R., a cura di (1993). *L'analisi della domanda in psicologia clinica*. Milano: Giuffrè Editore.
- Carli, R., & Paniccia, R.M. (2003). *Analisi della domanda. Teoria e tecnica dell'intervento in psicologia clinica*. Bologna: Il Mulino.
- Ceruti, M., Lo Verso, G. (1998). *Sfida della complessità e psicoterapia*. In Ceruti, M., Lo Verso, G., a cura di, (Eds.), *Epistemologia e psicoterapia. Complessità e frontiere contemporanee*. Milano: Raffaello Cortina.
- Clarkson, P. (1989). *Gestalt counseling in action*. London - Newbury Park - New Delhi: SAGE Publications [trad. it. *Gestalt counselling*. Roma: Sovera, 1992].
- Colucci, M. (2013). Fabrizio, con una zeta. Per una critica della ragione diagnostica. *Aut aut*, 357(1), 5-20.
- Cornoldi, C., a cura di (2007). *Difficoltà e disturbi dell'apprendimento*. Bologna: Il Mulino.
- Corradini, A., Crema, S., Lupo, M., & Saviane Kaneklin, L. (2011). *Etica e deontologia per psicologi*. Roma: Carocci Editore Studi Superiori.
- De Beni, R., & Moè, A. (2000). *Motivazione e apprendimento*. Bologna: Il Mulino.
- Dell'acqua, P. (2013). Se la diagnosi non è una profezia. *Aut aut*, 357(1), 59-76.

- Demetrio, D. (1990). *Educatori di professione*. Firenze: La Nuova Italia.
- Disanto, A.M. (2009). La costruzione della relazione educativa. *International Journal of Psychoanalysis and Education - IJPE*, 1(2), 49-88.
- Di Vittorio, P. (2013). Malati di perfezione. *Psichiatria e salute mentale alla prova del DSM. Aut aut*, 357(1), 37-58.
- Feyerabend, P.K. (1975). *Against method*. London: NB [trad. it. *Contro il metodo*. Milano: Feltrinelli, 2005].
- Frances, A. (2010a). Opening Pandora's box: The 19 worst suggestions for DSM-5. *Psychiatric Times*; February 11 [trad. it. Si apre il vaso di Pandora: le 19 peggiori proposte del DSM-5. *Psicoterapia e Scienze Umane*, XLV(2), 251-62].
- Frances, A. (2010b). DSM in philosophyland: curiouser and curiouser. *Bulletin of the Association for the Advancement of Philosophy and Psychiatry (AAPPP)*, 2, 21-25 [trad. it. Il DSM nel paese della filosofia. *Aut aut*, 357(1), 99-112, 2013].
- Freud, S. (1911). Il caso di Schreber. In *Opere 1905-1921*. Roma: Newton Compton, 1992.
- Fromm, E. (1976). *To have or to be?* New York: Harper & Row [trad. it. *Avere o essere?*. Milano: Mondadori, 1977].
- Galeazzi, G.M., Curci, P. (2007). Una controversia di trent'anni: Rosenhan, la diagnosi psichiatrica e il rapporto utenti-operatori. *Psicoterapia e Scienze Umane*, XLI(1), 39-58.
- Galli, P.F. (2014). Editoriale. L'anatra zoppa: DSM-5 e crepuscolo del diagnosticismo. *Psicoterapia e Scienze Umane*, XLVIII(4), 567-76. doi:10.3280/PU2014-004001.
- Gonon, F. (2011). La psychiatrie biologique: une bulle spéculative? *Esprit* novembre 2011 [trad. it. La psichiatria biologica: una bolla speculative? *Aut aut*, 357(1), 143-64, 2013].
- Heisenberg, W. (1984). *Ordnung der Wirklichkeit*. In Blum, W., Dürr, H.P., Rechenberg, H., a cura di, (Eds.), *Gesammelte Werke* (pp. 217-306). München: CI Piper [trad. it. *Indeterminazione e realtà*. Napoli: Guida, 2002].
- Iori, V. (2000). *Filosofia dell'educazione. Per una ricerca di senso nell'agire educativo*. Milano: Guerini.
- Iorio, G., Iorio, N. (2016). Il paradosso della nosografia psichiatrica del XXI secolo. *Modelli della mente-Open Access*, 1, 60-72.
- Jaspers, K. (1959). *Allgemeine Psychopathologie*. Berlin: Springer-Verlag [trad. it. *Psicopatologia generale*. Roma: Il Pensiero Scientifico Editore, 1964].
- Kagan, J. (1998). *Three seductive ideas*. Cambridge-London: Harvard University Press [trad. it. *Tre idee che ci hanno sedotto*. Bologna: Il Mulino, 2001].
- Kant, I. (1787). *Critica della ragione pura*. Milano: RCS, 1996.
- Laing, R.D. (1959). *The divided self*. London: Tavistock Publications Limited [trad. It. *L'io diviso*. Torino: Einaudi, 2001].
- Laudan, L. (1977). *Progress and its problems. Towards a theory of scientific growth*. Berkeley: University of California Press [trad. it. *Il progresso scientifico*. Roma: Armando, 1979].
- Marsonet, M. (1997). *La verità fallibile*. Milano: FrancoAngeli.
- Maslow, A.H. (1962). *Toward a psychology of being*. New York: D. Van Nostrand Company [trad. it. *Verso una psicologia dell'essere*. Roma: Astrolabio-Ubaldini, 1971].
- Migone, P. (2011). Presentazione dei principali sistemi diagnostici in psichiatria e alcune riflessioni sul problema della diagnosi. *Rivista Sperimentale di Freniatria*, CXXXV(2), 19-40. doi:10.3280/RSF2011-002003.
- Migone, P. (2013). Presentazione del DSM-5. *Psicoterapia e Scienze Umane*, XLVII(4), 567-600. doi:10.3280/PU2013-004001.
- Migone, P. (2015). Le due facce della psichiatria. *Rivista Sperimentale di Freniatria*, CXXXIX(2), 49-65. doi:10.3280/RSF2015-002006.
- Moè, A. (2010). *La motivazione*. Bologna: Il Mulino.
- Nicoli, D. (1994). La progettazione formativa nella formazione professionale. In Cortellazzi, S., Nicoli, D., & Vergani, A. (Eds.), *La formazione professionale. Problemi e prospettive*. Brescia: Editrice La scuola.
- Novak, J.D. (1998). *Learning, creating, and using knowledge: Concept Maps as facilitative*

- tools in schools and corporations*. Mahwah, New Jersey: Lawrence Erlbaum Associates, In. [trad. it. *L'apprendimento significativo*. Trento: Erickson, 2001].
- PDM Task Force. (2006). *Psychodynamic Diagnostic Manual (PDM)*. Silver Spring MD: Alliance of Psychoanalytic Organizations [trad. it. *PDM - Manuale Diagnostico Psicodinamico*. Milano: Raffaello Cortina, 2008].
- Putnam, H. (1990). *Realism with a human face*. Cambridge, Mass.: Harvard University Press [trad. it. *Realismo dal volto umano*. Bologna: Il Mulino, 1995].
- Rogers, K.R. (1942). *Counseling and psychotherapy*. Boston: Houghton Mifflin [trad. it. *Psicoterapia di consultazione*. Roma: Astrolabio-Ubaldini, 1971].
- Saraceno, B., & Gallio, G. (2013). Diagnosi, 'common language' e sistemi di valutazione nelle politiche di salute mentale. *Aut aut*, 357(1), 21-35.
- Sciacchitano, A. (2013). La diagnosi statistica. *Aut aut*, 357(1), 245-50.
- Spitzer, R.L. (2011). Psychological warfare: The DSM-5 debate. *HCPLive*; February 25 [trad. it. Intervista a Robert L. Spitzer. *Psicoterapia e Scienze Umane*, XLV(2), 248-50, 2011. doi:10.3280/PU2011-002007].
- Spitzer, R.L., & Frances, A. (2011). Guerre psicologiche: critiche alla preparazione del DSM-5. *Psicoterapia e Scienze Umane*, XLV(2), 247-62. doi:10.3280/PU2011-002007.
- Stella, A. (2002). *La relazione educativa. Complessità, transazione e intenzione nel rapporto educatore-educando*. Milano: Guerini e Associati.
- Stoppa, F. (2013). Un sintomo smarrito. A proposito della diagnosi borderline. *Aut aut*, 357(1), 251-265.
- Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. New York: W.W. Norton & Company Inc. [trad. it. *Teoria interpersonale della psichiatria*. Milano: Feltrinelli, 1975].
- Tosco, L. (1993). *Professione educatore*. Milano: FrancoAngeli.
- Wakefield, J.C. (2010). Misdiagnosing normality: Psychiatry's failure to address the problem of false positive diagnoses of mental disorder in a changing professional environment. *Journal of Mental Health*, 19(4), 337-51. doi:10.3109/09638237.2010.492418 [trad. it. Patologizzare la normalità: l'incapacità della psichiatria di individuare i falsi positivi nelle diagnosi dei disturbi mentali. *Psicoterapia e Scienze Umane*, XLIV(3), 295-314, 2010. doi:10.3280/PU2010-003001].
- World Health Organization. (1992). *Classification of mental disorders and behavioral disorders: clinical descriptions and diagnostic guidelines; ICD-10*. Geneva: WHO [trad. it. *ICD-10. Decima revisione della classificazione internazionale delle sindromi e dei disturbi psichici e comportamentali: descrizioni cliniche e direttive diagnostiche*. Milano: Masson, 1992].
- Zanniello, G. (1992). I problemi scolastici del 'rientro'. In: Zanniello, G., a cura di, (Ed.), *Interculturalità nella scuola*. Brescia: Editrice La Scuola.

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