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More family work and more work within the system is needed to develop the clinical practice. Comments to Parrella, Riefolo and Vincenti

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I really enjoyed reading the deep analytical comments of Carmine Parrella, Giuseppe Riefolo and Enrico Vincenti. In my comments to their reflections, I want to concentrate on some specific issues being glad that they referred on important elements of the more humanistic practice that I do not need to repeat.

I was also glad that they all were pointing out on a bit different aspects of my paper and on the psychiatric and psychotherapeutic practice on the whole. For instance, Carmine Parrella compared *Open Dialogue* (OD) with the Basaglia psychiatric reform in Italy. This is an issue that I have been thinking a lot and it has been raised in several projects of OD in Italy. While psychiatric reform in Italy had one of the main point of views the human rights of psychiatric patients, *Open Dialogue* is strongly based on developing psychotherapy for the most severe mental health problems. In the projects we have seen the integration of these two important perspectives, and I suppose that both parties have wone.

Parrella referred to the importance of training in Basaglia thinking. Training really seems to help to meet with people having psychotic problems in more human way. But I have also seen that something is still missing. And - I suppose - this is what OD can contribute with its psychotherapeutic roots. Sometimes it is not enough to respect the human rights and to be democratic, you also need training to tolerate the strange talks of the one we call as patient. The challenge may include the necessity to deal with the violence or the threat for violence of the patient towards other family members. Or to meet with any kind of extreme situations.

Vincenti analysed different parts of OD practice. As one of them he also

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made a comment about what in his mind is missing in OD. He pointed that 'I believe it is still necessary to make another step forward in order to enhance the author's contribution fully. Taking into consideration the context would allow us to insert the suffering person within his/her life environment and therefore, from my point of view, allows us to understand within these relationships the function that they have in maintaining the historical solutions that have configured them.'

After this statement Vincenti in a very friendly way starts to introduce his point of view saying that it is not only dialogue, but you really would also need an analysis and theory about the one who we call as patient and about the relationships that she/he is living in. He also gives some examples of this referring to the illustrated cases. I want to refer to this because this comment really comes into the very core of dialogical practice and my lesson that I have taken when making research and while being involved in the clinical practice within dialogical frame. According to my experiences, surprisingly, the less we 'analyse' the better it has become. I think that the long-term outcomes of patients who twenty years before had an experience of OD confirm this (Bergström *et al*., 2018).

I can agree that we need some concepts and theories to analyse our practice to understand and to learn to do it. But I don't any more believe that we need analysis of the system of the clients in the clinical practice. What is the exceptional element of dialogical practice is the fact that we never take things given, but - instead - every situation is changing all the time in a flow. In the dialogues from the very first minutes parents for instance can learn new ways of being in relation to their son or daughter. For instance, I remember one meeting with a mother and father and their 32 years old son who had been psychotic for 16 years, and still was in our first meeting. The parents really had been struggling with their son, his drug abuse, his extreme behaviour and so on. But they were so surprised when we with my co-therapists in the end of the session in our reflective conversation emphasized that they seemed to be so caring after these years and that neither of us had heard any negative word about their son. They both said that they could not believe that they were so positive about their son. They could learn something new about themselves in our dialogues and I suppose that this new made possible to mobilize more of their own resources to handle the situation. When thinking about the family as a systemic family therapist (the training I got early 80's) it would have been very easy to find non-functioning systemic rules within this family, but I don´t think that this had helped them in any way. On the contrary, it had directed our attention to non-functioning elements of the family and thus no new resources would have been mobilized.

Working with families has proved to be very challenging from the psychodynamic point of view. Perhaps one reason for this is that there is a

theory of the internal world of the psychotic patients. The internal problems relate to the relational experiences of the patients and of course the main part of the most important internal experiences happen within the family. In this *e.g*. the patient often wants to protect him from too close family relationships. At this moment difficulties emerge in seeing the importance of working with families. Many individual psychotherapists take the conclusion to work with the patient only, which gives limited results at least in two respects. First, this attitude does not help to find solutions to family problems. Secondly, the psychological resources will not be mobilized that live in the relationship between the family members. OD has introduced a way to deal with problematic family situations by accepting even the contradictory voices of the family members because the main issue in OD all the time is in generating dialogue, not in finding solutions.

Riefolo also gives a critical comment on OD when he notes that 'There are two levels of limitation to be considered. The first limitation is that OD seems to me to stop short at 'sharing and solidarity' of psychotic suffering, without grasping the transference communication dimension that - on a psychotic register - asks the therapist to get to know intimately, or even somatically (in the sense that it is a presymbolic register that perhaps is evident through actions, impotence, failure, errors and thus in enactment) what the specific nature of the psychological suffering of the patient is in that precise moment and with that subject. Another limitation that - as a psychoanalyst - I find in the OD approach is the sort of idealization of 'good practice' represented above all in the concrete dimension.' (Riefolo, p. 2)

I have to say that I did not fully understand this comment. If I understood correctly, Riefolo is saying that in OD psychotic experiences are not shared in solidarity. If my understanding is correct, I must apologize my paper not being clear enough about this. Sharing in embodied ways the suffering of our clients - including the one we call as the patient and the family members - is the very core of the dialogical practice. I like very much Riefolo's reference to the 'somatic' parts of the therapist's experience. I have used the word embodiment while referring to the fact that small part of the therapeutic process happens in words and in explicit formulations about the experiences and problems. In dialogue we do not aim at giving interpretations or other types of meanings to what the clients are saying, but instead of sharing their experience and jointly creating new language of their experiences that live in the not-yet spoken embodied experience. For me it is decisively important to stay in the utterances of our clients even so much that I try to avoid paraphrasing their comments, but instead merely repeat word by word some part of their words and ask to say some more about it. The 'curative' part of dialogue leys exactly in this: While including some new words about the experience what the therapist was repeating, people hear and learn more about themselves.

The critics about OD as idealization of 'good practice' is quite strange to me. If I am allowed to say some critical comments on the psychotherapy practice it is in this: Psychoanalysts and psychotherapists so often stay outside of the psychiatric practice thinking that their best contribution is doing psychotherapy merely mostly in private practice, but also sometimes in public services. And thus, the control of the practice is given to the people who really do not understand the importance of psychotherapeutic attitude in care. My claim is that one part of the success of OD is exactly in finding ways to integrate the organization of ourselves in the clinical practice and the clinical practice in the dialogical meetings. This is not idealization of good practice because in the studies we have focused a lot on the difficulties, failures, and other type of challenges. The practice only develops by the analysis of the practice itself by the practitioners themselves.

Riefolo also has an interesting analysis of the importance of 'specific' and 'aspecific' factors of the clinical practice. Perhaps you may say that in OD the specific factor is the aspecifity. The dialogue itself is the aim of the practice. This is different compared to the rest of psychotherapeutic methods, in good dialogue is seen as a tool to achieve something. For instance, a therapists may think that in good dialogue there emerge more options to speak about the most difficult issues in the life of the patients and within a good dialogue you can do deeper interpretations to increase the understanding of yourself. In dialogical practice I think that the new experience emerges in the new dialogical relationships and nothing more is needed.

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