Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXII, n. 3, 2021
doi:10.4081/rp.2021.603

From dialogue to accepting one's condition

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Introduction

Dealing with distress and suffering in a 'psychotic area of interest' raises several issues: the first concerns the fragility and delicacy of the person who is suffering, the way in which these fragilities are expressed, and their intersection with the fragilities and difficulties of those who are emotionally bonded to this person. The second relates to the 'mental health' professionals, the places of 'treatment', and even the contextual, cultural, and organizational dimensions of the Services they offer.

In his article, Seikkula describes the process that brought about the definition of an intervention model in psychiatry, the consequent organization of Services and training of personnel that together all aim to give people a voice; it is meant for all those that are touched by suffering and its purpose is to use listening as its main tool. This vision, as the author states, does not only deal with psychopathology and diagnosis, but also with the patient and the person he/she is. It presents an ethical dimension of listening and respect towards the person, going beyond the assertion of technical-operative competences. Consequently, focus is not put on the diagnosis in order to define the therapy and intervention, but rather, the diagnosis emerges from listening to the patient's voice and that of their relatives. The natural consequence of this type of approach is that it seems to lean towards a 'humanization of psychiatry and the services dedicated to it'.

Let us now follow the route described by Seikkula and towards the end of this article I will put forward certain considerations on this proposed method.

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Historical period

The first stages of the model date back to the 1960s, coincident with the need to transfer dozens of long-stay patients who were considered 'incurable' from the psychiatric hospital of Tornio, in Finland. The first issue that was raised, regarding the incurability of certain psychiatric pathologies, concerned the study of the correlation between intervention outcomes and the 'philosophy of treatment'. The basic idea was that dealing with the symptoms of psychiatric suffering would have opened the door to not listening and to the labelling of the patient and thus would have in fact involuntarily participated in the chronicization of the mental disorder.

Conversely, the mental healthcare provider's attitude shift, aimed more at listening to the person, was verified to see if it could contribute to the construction of a practice and a 'more optimistic treatment model', thus abandoning a reductionist view of a linear relationship between treatment and symptoms. Thus the model dealt with not only suffering expressed by the patient and was not limited to pharmacological treatment and individual therapeutic relationships. The field was broadened to include a familial and contextual dimension in the treatment process. This psychiatric project seems, although this is not directly expressed by the author, to insert itself within an international movement of criticism of the organic idea of human suffering; an attempt to listen to the person, to his/her voice and existential pain; thus, trying to give dignity to suffering and accommodating its single unique expressions.

To do this, it was necessary to leave the old logic behind, that of confining suffering to narrow and restricted places: closing off behind those walls everything that seemed extraneous, incomprehensible, and non-conforming to the predominant culture. I do not know the Finnish context well enough, and I do not know if, even in that territory, there were psychiatric hospitals and if the 'long-stay incurable' patients were represented by society as 'dangerous for themselves and others and/or that they disturbed public order' so much so that they were sectioned by decree of a judge or the police. In Italy this was the situation and from this a crisis of the psychiatric services and their underlying ideology was born with the movement 'liberation of psychiatry' and the democratization of its practices. This movement in Italy brought about the emanation of the 'Law 180' also known as 'Basaglia's Law', in honour of the biggest representative of the movement.

> '*It is then that the Psychiatric Diagnosis and Treatment Services in Italy (Servizi psichiatrici di Diagnosi e Cura) were started allocated within General Hospitals, Mental Health Centers, Crisis Centers and intermediate treatment structures located in municipal areas (foster homes, daycare centers and sheltered accommodation). The Basaglian ideal, that believes in the liberation of the psychiatric patient, is naturally connected to the 'liberation' of psychiatry, of its*

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> *practices and values, and those of society as well; the motto 'Free by Breaking Free' contained the idea of a clear connection between the different social forces and expressed the need of not segregating social distress as it is a simplistic and violent solution. It was necessary to bring suffering into the social sphere, reconnecting it with family, with work and society'* (Vincenti & Irtelli, 2018).

This was an expression of a psychiatry that was not 'oppressive and potentially iatrogenic', not made up of walls and containment, but a psychiatry that was open to the territory and to society. Thus, it was a psychiatry that differentiated from the medical concept and was closer to human and social sciences. A psychiatry that dealt with the suffering human beings within their context, considering them not only as organic but also as social and relational.

Psychiatrists, psychoanalysts, and health care professionals that have a different view towards human manifestations of psychiatric suffering focus do not only focus on symptomatology and diagnosis. They are not intent on eradicating the symptom, but rather are involved with patients in giving meaning as a manifestation that human beings are worthy of being respected in their essence.

As Borgna writes:

> '*Psychiatry is an ambiguous and perplexing discipline that, when opened up to interdisciplinary horizons of research, does not deal only with mental illness (psychic disorders) but with phenomena that are part of life, whether they are normal or pathological, and in particular with the boundless archipelagos of human emotions. Of course, if in practicing psychiatry we are not able to identify with the internal life of others, especially of others who are not well, and we are not able to be intuitive... it is not possible to understand fully the sense of pain and suffering, of sadness and anguish, of loss and lacerations of the soul, of silence and the amazement of the heart, that are all part of the human condition in its infinite forms of expression'* (Borgna, 2019).

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The proposal

Starting from Alanen's 'Need-adapted treatment', where different therapeutic methods were contemplated and used each time depending on the specific requirements of the situation, the Open Dialogue approach was organized. Meaning the 'way in which the psychiatric system is organized, both in the role of dialogue during sessions with patients, family members and healthcare professionals'. Thus, two different interconnected dimensions: one aimed at the patient, the other at the Service; both are united in their intent of favouring dialogue between the different components: in the treatment between patient, relatives and support network; in the Service between users, équipe and extended network.

Patients are actively involved, together with their relatives, in defining

the problems and in searching for solutions; this is an active part of the treatment process and, as Alanen believed (reported via Seikkula), attention is paid on strengthening the adult side of the patient and the normalization of the situation, instead of concentrating on regressive behaviour. In detail, individual attention towards the patient is combined, via an individual dynamic therapy, to attention towards the family and the context, via an intervention that moves in the direction of systemic family therapy. Seikkula is keen to stress that the attention of the therapist is not aimed at creating a specific way of conducting the session but is oriented towards listening and answering. A listening that is not rational but empathetic participation 'indeed, it seems that the passage from rigid and restricted monologic discourse to dialogue comes on its own when painful emotions are not treated as dangerous, but rather are left to flow freely in the room'.

Consequently, health care professionals are urged and trained to let themselves enter into active participation and answer, to what the interlocutor brings, person to person, and better still starting from their very words. It is a dialogic relationship in which an attitude of maximum availability to listen to another, through our incarnate presence, is expressed in a verbal and non-verbal way; thus, listening and 'normalizing' what one says, even in a psychotic form. This way of proceeding responds to the theoretical premise, called to mind also by Bakhtin, 'being means communicating dialogically… in dialogue a person does not only show himself/herself externally, but becomes what he/she is for the first time …not only for others but even for themselves'.

After all, there is a preconception: patients are ill because they cannot speak or make sense of what has happened in their lives. It is a sort of traumatic situation and an intervention based on dialogue can make patients and their families and support network (in connection between themselves) reclaim and give meaning through an emotional sharing of the experience. It must be underlined that emotional participation and sharing, carried out through reconnecting each person with their own painful themes is extremely important. Being able to stay on these themes and in uncertainty has a therapeutic goal. Certainly, this goes beyond a medical model based on a symptom that must be eradicated and on a relationship between an expert professional 'who knows' and an ignorant patient that needs to be treated. This is an open model in which the professional and the components of one's network are invited to get involved first hand.

Although I also share in the belief that there is a need to move away from an organicistic and unidirectional model, I do not find myself completely in alignment with Seikkula's model. Not because I find sharing and participation with one's network and context useless, but because of the antecedent theoretical idea. Seikkula proposes a model that certainly considers complexity, so much so that he understood the importance of

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keeping in mind the subject and his/her relations, not stopping only at an analysis of communication and relationships but trying to make sense of the world of the patient. This general idea and its consequent practice have surely brought us forward in the conception of psychosis as bringing about distress and human suffering, that is non-reductive to only an organic and biological component. This thought brings with it a positive vision of both the person and of the evolutionary possibilities in distressful situations.

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. Various authors, such as Maturana, have examined the organization and functioning of a human being within his/her environment and Oyama clarified how auto-eco organizational processes and repetitive circular elements are the basis of our existence. Sander (2003) was the first psychoanalyst who tried to transpose these concepts to the human being, and he states that we cannot think of 'any human being… without thinking about his/her environment within which he/she is continuously interacting… as a 'system': the organism and its environment'. On the basis of what was described by these authors, we can try to hypothesize how humans organize themselves and how they work. If human beings can auto-eco organize within their environment we can think that it is also the environment that has defined them and that the human contributes to this defining. From this it follows that the relationships with each subject are functional in maintaining one's configuration, through continuous processes of circular recurrences.

On this level, that Minolli defines as 'conscious' (so a level of processing that is analogous to all living organisms), a relationship (of any kind) is functional for each participant in maintaining their own configuration and in affirming themselves. In the pursuit of this vital goal, often there are attributions of 'delegation' to another. By delegation Minolli means everything that subjects use when they have difficulty coping on their own, taking their lives into their own hands, their own story and their own relationships.

Seikkula offers an exemplar description of the attributions of reciprocal delegation when he writes:

> *'Different network members live in very different, even contradictory, situations, and thus have very different ideas of the problem. Consider a crisis surrounding a mother, father, and son, in which the son, suspected of drug abuse, becomes nearly psychotic. The father may be concerned primarily about the family's reputation among his co-workers and the mother about her son's health, and the young man may protest angrily that he does not need any treatment and that his parents are crazy and should seek treatment for themselves.'*

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From this you can clearly see how these three people are struggling to deal with their own existence, with the consequence that each is attributing responsibility of their difficulties and malaise to another. Making them work together could be an opportunity, not only to share and find meanings that were inaccessible before, but also to help them confront the reciprocal support, requests and pretenses towards one another, helping them to recognize the attributions of delegation and trying to help them cope on their own by having faith in themselves.

A similar discussion on the use of delegation could be made for the treating team. Attributing and insisting on attributing the difficulties of a person who comes to the Service due to an organic cause, trying to eliminate a symptom, for example with anti-anxiety medication or antipsychotics, could represent a difficulty in putting oneself out there, in embracing the suffering that our interlocutor brings. This pretense is formalized and institutionalized within a theoretical vision and a treatment method where there is an 'expert' who knows and a patient who is 'uninformed' in how to be treated.

I believe it is natural to operate in this way because it responds to the vital need of the subject to assert what he/she is within a specific context. This need applies to everyone: the patient (who asks or for whom it is asked to intervene), the relatives and the healthcare professionals. In the sense that everyone is involved in the vital task of continuing their existence asserting what they are, and how they have configured themselves based on their genetic heritage passed on by their parents and on the significant relationships and the context in which they find themselves. Dealing with these relationships, keeping in mind their function, respecting the organization and solution of each as functional to living, as they are the best solutions that each of us has tried out in order to exist, is the premise for a respectful intervention.

Listening to patients, their relatives and the members of their support network concretizes the 'approach' of the healthcare professional in a real and direct relationship with another person and their suffering, thus renouncing on one's position of power as the all-knowledgeable director. I think that the outcomes presented by Seikkula regarding the reduction in symptomatology and the lower use of psychotropic drugs and interventions or the need to be admitted to hospital are all attributable to the change in intervention paradigm.

It is an uncomfortable position to be in because we find ourselves empty-handed with the other person and with ourselves. Thus, we must concretize the possibility of staying in uncertainty, because we may lose our strongholds and 'presumed' technical competences in order to touch human suffering first hand, in this way we find solutions and expressions for those who ask for help. The emotional impact of this situation has to do with the dimension of presence. Thus, the training of healthcare professionals is a fundamental passage as it is necessary to accompany them in abandoning their presumed technical competences, in order to acquire a different awareness of

themselves, so that they can 'withstand' the impact of the human condition, in every form of expression.

The équipe

Due to the desire and difficulty in confronting psychotic suffering in the second half of the last century, in many contexts they felt the need to actively involve members of the treating team in the treatment process and to continuously train them. I am thinking for example of Racamier and the pioneering work described in 'The Psychoanalyst with no sofa: Psychoanalysis and Psychiatric institutions'.

After all we can state that the work addressed to the treating team found its basis in the idea that the dynamics between the healthcare professionals were expressions/projections of the internal world of the patient. Thus, the effort was directed at the analysis of interpersonal dynamics by members of the équipe in order to overcome splitting and have an integrated view of the patient. In this way the team was functional and was seen as an 'organ' of digestion/comprehension of suffering in order to present it back to the patient.

Seikkula proposed a further step in that it is not the treating team who pre-digests what the patient cannot digest and then gives it back to the patient, but it is the working together with the patient that forces us to find a meaning through the continuous participated exchange, so that new words and new discussions can emerge regarding the suffering.

In what I have written so far, I have described the author and inserted his proposal within a general cultural evolution in the Western world. I would now like to take it a step further, because if the proposal brings a positive vision of patients, and of their involvement in the research of a different conception for their well-being, positioning the evolutionary possibility in the 'respondent dialogue', allows what went out the door to come back in the window: it is a limited vision of human beings and condemns them to an eternal dependence on others. The respondent dialogue could run the risk of attributing the evolutionary possibility of dialogue to the response of others, underestimating the possibility/capacity of the human being, through the consciousness of the conscience, of dealing with one's own suffering, of welcoming it in one's life and trying to find another way to go on. This is a capacity that we must think is possible for each human being, even the so-called psychotic patient.

The politics of services

I have not dwelled on the technical indications and operational proposals, because they are consequential to a described theoretical vision: response

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within 24 hours, taking charge of the patient's care, continuity and guarantee of continuation on behalf of the treating team *etc*. these are all expressions of the need to taking care of the person who is suffering.

Just as, opposingly, the non-continuity in the care of the patient, the continuous jumping from one healthcare professional to another, the not counting on the treating team and the continuity in the treatment relationship, are direct consequences of the theoretical view of the human being, considered as Stolorow calls it an 'isolated mind' and its suffering due to a biochemical alteration.

Psychiatry, as Borgna states, is considered a Cinderella within medicine, tolerated but never fully accepted. Even the healthcare budget given to psychiatry (and even the attention given to the organization of Services) leaves much to be desired. Unfortunately, in the last few years in Italy, we have seen a precariousness of the treatment team, a continuous change in psychiatrists and healthcare professionals that with difficulty can be compatible with taking care of suffering and of people.

Fortunately, not all services are organized in this way, there are excellent examples of the use of limited economic resources that give value to human resources, 'an instrument' that is important in the taking care of psychiatric suffering.

It pleases me to know that in Finland and in certain other countries, Seikkula's proposal has taken root, because it represents an effort towards a vision of humans and a respect towards their way of being. Especially in spheres that are considered incomprehensible, such as 'psychotic' suffering.

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REFERENCES

Basaglia, F. (2000). *Conferenze brasiliane*. Milano: Raffaello Cortina.

Basaglia, F. (a cura) di (1968). *L'istituzione negata.* Torino: Einaudi.

Borgna, E. (2019). *La follia che è in noi (ebook - Vele vol.149).* Torino: Einaudi.

Ferro, A., Jervis, G. (1999). *La bottega della psichiatria*. Torino: Bollati Boringhieri.

Maturana, H. R., Varela, F. J. (1985). *Autopoiesi e cognizione. La realizzazione del vivente*. Venezia: Marsili.

Maturana, H. R., Varela, F.J. (1987). *L'albero della conoscenza.* Milano: Garzanti.

Minolli, M. (2004). Per un Io-Soggetto fatto di legami. *Ricerca Psicoanalitica, XV*(3), 317-329.

Minolli, M. (2015). *Essere e divenire*. Milano: Franco Angeli.

Oyama, S. (2004). *L'occhio dell'evoluzione,* tr. it. Roma: Fioriti.

Pichon-Rivière, E. (1985). *Il processo gruppale, dalla psicoananlisi alla psicologia sociale*, tr. it. Loreto: Lauretana.

Racamier, P. C. (1982). *Lo psicoanalista senza divano*. Milano: Cortina Editore.

Racamier, P. C. (1998). *Una comunità di cura terapeutica*, tr. it. In Ferruta, A., Foresti, G., Pedriali, E., Vigorelli M. (a cura di), *La comunità terapeutica. Tra mito e realtà.* Milano: Cortina Editore.

Sander, L. (2005). Pensare differentemente. Per una concettualizzazione dei processi di base dei sistemi viventi. Trad. it. *Ricerca Psicoanalitica, XVI*(3), 267-300.

Sander, L. (2007). *Sistemi viventi. L'emergenza della persona attraverso l'evoluzione della consapevolezza*, tr. it. Milano: Cortina Editore.
Stolorow, R. D., Brandchaft, B., Atwood, G. E., Fosshage, J. (1999). *Psicopatologia intersoggettiva.* Urbino: Quattro Venti Edizioni.
Sullivan, H. S. (1977). *Teoria interpersonale della psichiatria*, tr. it. Milano: Feltrinelli.
Vincenti, E. (2006). Alcune risposte della Psicoanalisi Relazionale alle gravi configurazioni psicopatologiche. *XIV International Forum of Psycoanalysis*, 23-27 maggio, Roma.
Vincenti, E. (2016). Dentro e fuori la stanza d'analisi: l'intervento in una struttura residenziale psichiatrica. In Corbelli, L., Fontana, M. (a cura di), *Psicoanalisi e schizofrenia*. Milano: FrancoAngeli.
Vincenti, E., Irtelli, F. (2018). A quarant'anni dalla Legge 180. *Ricerca Psicoanalitica, XXIX*(3), 37-51.

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Conflict of interests: the author declares no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received for publication: 9 November 2021.
Accepted for publication: 9 November 2021.

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Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2021; XXXII:603
doi:10.4081/rp.2021.603

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