Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXII, n. 3, 2021
doi:10.4081/rp.2021.589

A few considerations about: *Open Dialogue - a new psychotherapeutic approach oriented towards human rights so as to devise humanistic psychiatric services*

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I read Seikkula's contribution to this issue with great interest. Let me first say that I do not consider myself an expert on *Open Dialogue* (OD), but I can count on my long experience of working in local Italian Public Mental Health Services and my clinical work as a psychoanalyst in the psychoanalytic room. I must also state that for me the two positions are inextricably connected as I feel psychoanalytic both during analysis and when conducting other services. Moreover, I have experience of interventions with psychotic and borderline patients in the acute phase and in outpatient settings. In these settings I find there is a deep harmony with the OD approach. I agree with the central position of OD whereby dialogue is represented not so much in its 'communicative' function, but in its representation dimension of the subject as a creative act of new meanings. Furthermore, communication, according to van der Kolk (2014) and other psychoanalysts who have an intersubjective approach, has the function of narrating and presenting emotions which have never been described before to an interlocutor. I had an idea that is in line with certain psychoanalytic approaches which suggest that dissociation is a physiological tool for mental organization (Bromberg, 2006). The use of dialogue can be represented as a tool that activates the physiological 'dissociative process', removing the impasse position that characterizes the patient on a clinical level, as a block with repetitiveness and rigidity (Ginot, 2015). Lastly, there is no doubt that a 'needs-based approach' opens up channels for sharing and communication with the most needy and distressed states that are the basis of psychotic suffering, especially in the acute phase. A psychoanalyst must ask himself/herself what is meant by 'needs', and therefore, if in the so called

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'needs-based approach' there are collusion and suggestion positions implicated - and to what extent - (these are elements that are always present in psychotherapeutic processes, but the problem is how to evaluate them and what use to make of them…). The results evidently document this important change compared to 'treatment as usual' (TAU). In line with this, it has also been reported that if one tries to treat (I would prefer to say, in a Winnicottian way, *take care of*) patients, from the beginning, treatments would be more economical due to a reduction in hospitalizations, subsidies, retirement and use of medicines.

At this stage I will try to discuss two issues with this approach, but I want to reiterate my full acknowledgment of the positive potential of OD. On the one hand I am interested in understanding what the specific factors of the OD approach are, and on the other, what the indications to which OD is proposed as a more capable approach are.

Regarding the first issue, in my opinion, the evaluation of a therapeutic method cannot be avoided. I believe we cannot escape clarifying what we mean by 'specific and aspecific factors'. Some researchers have dealt with this when trying to evaluate the efficacy of a therapeutic approach (Migone, 1996; Roth & Fonagy, 1997; Stern, 1995). Even so, most studies (I must confess I know only a few and mainly those in the psychoanalytic field…) find that therapeutic approaches are valid for the first six months, independently of the characteristics of each specific model used. The aspecific factors communicate to the patient that we are willing to accommodate him/her, to share in their pain and impotence together and to give a sufficient dose of hope in the resolution of the block caused by psychotic suffering. I believe it important, in an aspecific way, that 'once sentiments have been widely shared in the session, the experience of relational treatment becomes palpable'. I consider aspecific elements to be the central and determining parts of a successful approach, for instance: intervention within the first 24 hours; involving all the patient's significant others; and the direct involvement of the patient in defining the therapeutic process. These are all positions of high subjective availability on behalf of the therapist that surely - independently of the clinical model used - result in improvements of the clinical picture of the patient. I repeat that I am not an expert in OD, but the issue of specificity of the OD approach remains. Those that Seikkula refers to as specific factors of the OD approach, can all be seen in other models. For example: 'attention is given to strengthening the adult side of the patient and normalizing the situation, rather than concentrating on regressive behaviour'. This is an approach used also in relational, intersubjective, Ferenczian and Winnicottian psychoanalysis. If anything, we could ask ourselves in this case what Seikkula means by 'the adult side of the patient'. The OD approach evidently refers to the more operative, concrete and competent dimension of the patient. The relational analytic approach refers to the competence of the patient in knowing how to recognize

his/her abilities in the creative order that, in any case, are not in contradiction with the recognition of concrete competences of the patient. One of the most important aspecific elements is the trust that the therapist tries to earn - directly and concretely - from the patient. In line with this, it is also true that the best results are obtained the more the patient or the situation is serious and that in these cases solidarity is a communication of a strong tuning into the patient - as Kohut could have suggested (1984) - that 'when one empathizes with a psychotic, from that moment forward the patients stops being one'.

Subsequently we have the specific factors. For family or cognitive behavioural therapy, the idea is to undo the pathological bonds that tie members of the family together and that assign the patient as designated bearer and more fragile member of the entire pathological family system. In a psychoanalytic approach it is about accommodating the communication of the patient on a transference level and also about projective identification; giving back to the patient his/her modulated identifications that have been transformed by the participation of the analyst (Bion, Ogden, Bollas, Ferro…). There is also the solicitation of acting-out on behalf of the analyst through enactments brought about by the patient (Bromberg, 2006; Boston Change Process Study Group, 2010; Boaccara, Meteangelis & Riefolo, 2018) and read according to codes of intersubjective dialogue and reciprocity (Benjamin, 2017; Reis, 2020). In the end, the 'seven fundamental principles' on which OD is based could be seen as essentially aspecific and thus, common to other therapeutic approaches of a psychodynamic order. For example, when members of a treatment team feel emotional, they are asked to 'tolerate intense emotional states brought about during the session'. This is all very well, but we could ask ourselves: what use do therapists have of this sharing of intense emotional states? It is obvious that the patient, in sharing, recognizes actively that he/she is able to modify the emotional state of the caregiver (Stern, 1985). However, in what way does that emotional state and to what extent does it belong to the patient (transference) and as such puts the therapist in a dimension of '*role responsiveness*' (Sandler, 1997) or asks the therapist to restitute the dissociative elements of the Self that tune into the dissociative states of the patient?

The second issue that stems from reading Seikkula's proposal is to ask we to what models OD refers to in order to reaffirm the specific difference (compared to other approaches) and more importantly the enhanced therapeutic potential. The first model of confrontation (which I would say is inevitable) is with descriptive and objectifying psychiatry. Indeed, OD presents itself as an alternative to the 'monological rigid and limited discussion'. This obviously allows for positive results because we acknowledge the violence and restricted openness to dialogue in traditional psychiatry. The references could be on a different level and perhaps, more specific. For example, how could the discussions be carried out in services for Borderline

patients such as those of Russel Meares in Australia (which are in fact characterized by a dimension of opening up creative dialogue), or the patients of Marsha Linehan or Fonagy and Target with their therapeutic models? The comparison with traditional psychiatry, in mi view, does not say much because the bar of traditional psychiatry is notoriously low or inadequate.

On a dynamic level the other comparison model seems to be family therapy, represented in its dimension of coded position and enclosed within a rigid setting especially when we refer to a 'professional used to working in a more structured way'. However, the OD approach can allow for an opening up to the setting and more solicitations to the direct participation of the patient. I agree, especially in the case of serious episodes or psychotic states, that a family therapy setting can result in difficult application and the proposal can be felt as distant and violent on behalf of the patient. In a more implicit way, it seems to me that a third level of comparison is the psychoanalytic one. In any case and always in line with the 'aspecificity' of the structural elements of OD, every other therapeutic method used in psychotic situations is called to modulate its setting to accommodate the psychotic symptomatology of the subject positively. Compared to other models, OD has the advantage of expanding its position of 'accommodation and solidarity', actively within the family context of the patient and within the multidisciplinary team. It is certainly an advantage (but I believe this to also be aspecific) that it has positive outcomes as it communicates the possibility of experiencing relational harmony that breaks the autistic niche in which the patient defensively shelters himself/herself in during the psychotic explosion.

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.

For me the risk is that we idolize the theoretical and clinical position keeping it separate from concrete feasibility. In this sense my position is clear: as clinicians we must 'do our best with what we have' (Winnicott). If we refer to ideal solutions which are concretely unfeasible this represents a potentially violent position and non-assumption of clinical responsibility. This position has, over the years, constantly led to positions of serious 'lament' (Riefolo, 2017) on behalf of operators towards the frustrating impossibility to carry out overdetermined projects. While our task should be to find an environment that allows for the highest level of relationship pos-

sible (tuning in) with the patient even when this tuning in solicits the sharing of impotence towards concrete needs. A possible doubt could be that the OD approach is implicitly organized around a concrete availability of services in a northern European society such as the Finnish one. I would find it very violent to propose an intervention model that is possible in Finland but that does not consider the peculiarities in the context in which we are called to intervene. It is not a problem of more or less resources (indeed we all know that in some cases there is a waste of economic resources with anti-therapeutic results), so rather than costs, it is about a cultural clinical problem where a therapist must use concrete elements creatively and which he/she - truly - possesses (Riefolo, 2020). On a dynamic level, this means having the possibility of creating a specific setting that can accommodate psychotic suffering. OD proposes the use of 'natural settings', but this is different - on a dynamic level - from *making the setting* using the natural elements that are available and that before they can be accepted, they must be used. The setting is a specific tool that attributes meaning to what happens. A simple example: it is one thing to positively accept that a patient asks to eat on his/her own during a psychotic crisis until he/she feels reassured. It is another thing to read these movements that the patient makes in eating on his/her own, or with others as availability to trust therapists and thus access treatment. The difference between the first and second position is the use of the setting according to a natural or transference register.

In psychodynamic psychiatry (especially in psychoanalysis), the setting, with its rules and 'limitations' is an integral part of the process. All that happens (or does not happen) in the setting has immediate references to dynamic unconscious potentials. What I mean to say is that if in a service which has serious concrete shortcomings, I make concrete and unachievable proposals, this is not simply an 'oversight', but a violent and manic position that resolves the impotence of the patient, but does not accept it and projects it violently into contexts that we are not involved in. (Riefolo, 2017). In summary, we must remember that OD in an Italian context (unlike in the case presented) must acknowledge that it is not possible for the 'GP to immediately contact a psychologist in their local mental health clinic' or that there may not be a 'specific place for acute crises to guarantee the immediate organization of a meeting' available and that in one day there is the possibility of organizing an intervention team for the crisis or that this team can carry out 'a home visit that same day in the afternoon.'

In conclusion: I want to reiterate the profound conviction that the theory of OD is extremely interesting and valid on a psychodynamic level, I have tried to discuss the possible specific factors of the approach and, within a dynamic setting, the outcome of the process of feasibility of these positions; it is my conviction that the feasibility cannot be separated from the therapeutic process and is particularly connected with the outcomes of treatment.

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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 August 2021.
Accepted for publication: 28 August 2021.

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Ricerca Psicoanalitica 2021; XXXII:589
doi:10.4081/rp.2021.589