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Healing through dialogue. An Open Dialogue experience lived by a novice psychiatrist

Guarire attraverso il dialogo. Un'esperienza di dialogo aperto vissuta da uno psichiatra alle prime armi

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Abstract

This article explores the transformative power of dialogical practices, particularly within the context of Open Dialogue, as experienced by a novice psychiatrist. The narrative delves into the journey of "Ponti di Vista," a collective of psychiatric professionals seeking to engage with diverse realities in mental health beyond academic boundaries. Through encounters with the practices of Open Dialogue, characterized by transparency, tolerance of uncertainty, and emphasis on relational focus, the article elucidates the fundamental principles and key elements of Dialogical Practice. By incorporating Dialogical Practice in mainstream mental health, professionals can create a more inclusive and collaborative approach to treatment. This can lead to a deeper understanding of each individual's unique experience, fostering empathy and empowering patients to actively participate in their own healing process. Furthermore, Dialogical Practice can challenge traditional power dynamics within the mental health system, promoting a more democratic and person-centered approach to care.

The narrative further reflects on the impact of dialogical approaches on fostering mutual understanding, empowerment, and collaborative care. Drawing from experiences in Caltagirone, Sicily, the article underscores the significance of cultivating emotional bonds and creating supportive networks within mental health care settings. This paper concludes with reflections on the challenges and possibilities of adopting dialogical practices in broader mental health services, advocating for incremental reforms based on empathetic engagement and transformational dialogue.

Riassunto

Questo articolo esplora il potere trasformativo delle pratiche dialogiche, in particolare nel contesto del Dialogo Aperto. La seguente è una narrazione di questa esperienza vissuta con e attraverso il collettivo di "Ponti di Vista", un gruppo di operatori della salute mentale che cercano di convogliare realtà diverse nel contesto più generale del benessere mentale e di comunità al di là dei confini accademici. Attraverso gli incontri con le pratiche del Dialogo Aperto,

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caratterizzate dalla trasparenza, dalla tolleranza dell'incertezza e dall'accento sul focus relazionale, l'articolo chiarisce i principi fondamentali e gli elementi chiave delle pratiche dialogiche. Sottolinea l'importanza del dialogo inclusivo tra terapeuti, membri della famiglia e reti sociali, enfatizzando l'ascolto attivo e la risposta alle narrazioni dei clienti. La narrazione riflette inoltre sull'impatto degli approcci dialogici nel favorire la comprensione reciproca, l'empowerment e la cura collaborativa. Attingendo dall'esperienza a Caltagirone, in Sicilia, l'articolo sottolinea l'importanza di coltivare legami emotivi e creare reti di supporto all'interno dei contesti di cura della salute mentale. Conclude con riflessioni sulle sfide e sulle potenzialità dell'integrazione delle pratiche dialogiche nei servizi pubblici di salute mentale, sostenendo una riformulazione del legame sociale attraverso l'empatia e il dialogo trasformativo.

Introduction

To understand how I encountered dialogical practices, we need to take a brief journey into the collective I am a part of: "Ponti di Vista". We are a group of friends and colleagues from the psychiatric field that was formed during our specialization years in Naples. The group was created by our curiosity about what lies beyond the university, in the territory, in mental health, out of the necessity for communication and engagement with a variety of and diverse realities, including users, professionals, families, third parties, and other disciplines of humanity. The main goals and objectives of the "Ponti di Vista" group are to promote dialogue and collaboration among professionals, users, families, and other stakeholders in the field of mental health. By engaging with diverse perspectives and realities, the group aims to enhance understanding, improve the quality of care, and advocate for inclusive and holistic approaches to mental health. In this movement towards the outside, the Collective initially encountered, albeit at a distance due to the Sars Cov-2 pandemic, Raffaele Barone, Director of the Department of Mental Health of Caltagirone - Palagonia (CT), and his team of operators, thus coming into contact with the reality of Open Dialogue and the set of Dialogical Practices in its Sicilian declination. Incorporating Open Dialogue practices into the objectives of the "Ponti di Vista" group could bring numerous benefits. The group could gain a valuable framework for fostering open and inclusive communication, as well as a deeper understanding of the perspectives of users, families, and other stakeholders in mental health. By embracing Dialogical Practices, the group may enhance their ability to provide holistic and person-centered care, ultimately improving the overall quality and effectiveness of their interventions.

Dialogical practices emerged as an approach to help psychiatric patients and their families feel listened to, respected, and valued. Since 1984, at the Keropudas Hospital in Tornio, Finland, the ways of admitting patients began to change. Following the work of Yrjö Alanen, the response to acute crises changed by instituting a group meeting, reuniting the patients, their family, other friends, and all the involved operators, before making any decision regarding the hospitalization. This was the birth of a new open practice that developed, along with continuous clinical innovation, organizational changes, and research, into

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what is now known as "Open Dialogue", described for the first time as such in 1995 by Jakko Seikkula. The concept of "openness" in Open Dialogue refers to the transparency of programming and decision-making processes, which take place in the presence of all stakeholders (Seikkula, 2023). This does not mean that family members are obliged to speak out on issues that therapists believe should be addressed frankly.

From the beginning, this network approach was applied to all therapeutic treatment situations. Within a decade, the traditional hospital structure in Tornio was transformed into a complex psychiatric system, with continuity of care both in the community and on an outpatient basis starting from the acute hospitalization situation. Therefore, Open Dialogue practice has two basic characteristics: an integrated community-based system of care that involves family members and social networks from the first moment help is sought, and a “Dialogic Practice,” which is a specific form of therapeutic conversation.

The central core of OD

Engaging in transformative dialogue with people requires presence and attention to the present moment, without preconceived assumptions or specific agendas. The art and skill of Dialogical Practice lie in the fact that therapist communications are not formulaic. Open Dialogue involves the ability to listen and adapt to the particular context and language of each exchange. For this reason, it is not possible to provide, in advance, specific recommendations for sessions or for presumed specific phases in the care process. Prescribing this under a precise structural form could actually hinder the Open Dialogue process (Ong, Buus, 2021). It is the unique and idiosyncratic interaction between the components of each specific group of participants, engaged in a therapeutic conversation, which inevitably produces possibilities for positive change. At the same time, there are systematic elements of Dialogical Practice. In this way, a paradox is created. Although each dialogue is unique, there are distinct conversational elements or therapist actions that generate and promote the flow of the dialogue and, in turn, help mobilize the resources of the person at the center of the issue and the network.

This is what we mean by the term "key elements". These will be defined and described below. Dialogical Practice is based on a special type of interaction, the fundamental characteristic of which is that each participant feels listened to and finds appropriate responses. With an emphasis on listening and responding, Open Dialogue encourages the coexistence of multiple, separate, and equally valid "voices" within the care meeting. This multiplicity of voices in the network is what Bakhtin calls "polyphony" (Seikkula, 2011). In the context of an acute and serious crisis, this process can be complex and require a certain sensitivity in eliciting and giving voice to those who are silent, speak less and are hesitant, frustrated, or difficult to understand. Within a "polyphonic conversation", there is room for every voice, thus reducing the distance between the so-called "distress" and "well-being". Collaborative exchange among all the different voices weaves ways of understanding that are new and more shareable, to which each contributes significantly. This leads to a common experience that Bakhtin

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describes as "without hierarchies". The twelve key elements of Dialogical Practice (Seikkula, 2014) in Open Dialogue are as follows:

1. Two (or more) therapists in the team meeting. The Open Dialogue approach emphasizes the importance of a group of therapists working as a team with the social network. There should be at least two therapists per meeting. Teamwork is essential for effectively responding to severe crises, acute conditions, and chronic psychiatric conditions. One therapist may engage in dialogue with the client(s), while the other takes a position of listening and reflection. On the other hand, it may happen that both ask questions and engage in reflection. The two operators leading the meeting can be from different disciplines.
2. Participation of family members and social network. By valuing the inclusion of family and other social network members from the outset, they typically become important partners throughout the care process. At the same time, there is flexibility based on the willingness of the person at the center regarding the participation of their relatives. Therefore, the team may meet separately with different family members and network individuals when joint meetings are not possible, as in many cases of violence and abuse (Buus et al., 2021; Ong & Buus, 2021)
3. Use of open-ended questions. The actual care meeting begins with open-ended questions asked by clinicians. After introductions, an opening might be formulated by simply asking, "Who would like to start?" or "What might be the best way to begin?". Once this collaborative process is established and well received, subsequent meetings proceed naturally as a given element. In the first meeting, it is important to emphasize the two questions with which an Open Dialogue meeting begins, namely: "Where does the idea of coming here today come from?" and "How would you like to use this meeting?"
4. Responding to things said by the client. The therapist promotes dialogue by responding to things said by the client usually in three ways that invite further responses. These ways may include using the client's own words; engaging in responsive listening; staying in touch with non-verbal communications, including silences.
5. Emphasizing the moment. The clinician emphasizes the present moment of the meeting. This means both responding to immediate reactions occurring in the dialogue and allowing emotions to emerge.
6. Soliciting multiple viewpoints. Open Dialogue does not aim for consensus but for a confrontation and a creative exchange of multiple voices and viewpoints, even if these differ among people or within the same individual. There are two dimensions of multiplicity of viewpoints and voices, or polyphony: (A) exterior and (B) interior. In exterior polyphony, the therapist involves everyone in the dialogue, encouraging all voices to be heard and respected, while at the same time integrating incongruous language and managing a dialogue instead of a monologue. In interior polyphony, the therapist listens and encourages each person to clearly express his or her point of view and experiences in depth.

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7. Use of Relational Focus in Dialogue. Interviewing clients, dialogical therapists are interested in working on themes and issues within a relational framework. For example, when a family member is angry and critical towards a therapist, it is not framed as a manifestation of "personality disorder", but as a reaction to an actual relationship and interaction with that specific professional, thus making anger a voice within a polyphonic conversation.
8. Responding to Dialogical and Behavioral Issues with Concrete and Meaningful Styles. In Dialogical Practice there is an emphasis on "normalizing discourse" as opposed to speaking about issues as if they were pathological, which is often the starting point of discourse. The therapist listens to the meaningful and "logical" aspects of each person's response. This means that the therapist makes an effort to comment on and respond to what has been said. in a way that considers symptoms or problematic behaviour sensible, i.e., "natural" reactions to a difficult situation.
9. Emphasizing Client's Words and Stories, Not Symptoms. Dialogical Practice encourages the narration of what has happened in a person's life, their experiences, thoughts, and feelings, rather than focusing on symptoms. Storytelling can occur easily or may require an intentional search for language. Opening formulas starting from a word or fragments of sentences can be keywords with very relevant associations of ideas with the problematic situation. The therapist focuses on the words that can provide access to the person's narrative of suffering. This is part of a broader process of developing a common language and a more complete story. In this way, severe symptoms can be understood as expressions of unspeakable or difficult-to-explain dilemmas. They are often rooted in terrible and frequently traumatic experiences that are resistant to normal language and normal narrative expression.
10. Conversation among Professionals (Reflections) in Care Meetings. In every meeting, the conversation among a professional and others should be emphasized. When it happens, it is recommended that therapists speak to each other and not address the family or any other participant. There are three parts to the conversation in front of family members. The first two are interchangeable, but the third always takes place after the dialogue among professionals. Firstly, there is the reflection process, where therapists engage in reflections centered on their personal ideas/images/associations, with the client and family present. Secondly, therapists converse with other professionals during the meeting to plan care, analyze the problem, and openly discuss their recommendations regarding medication and possible hospitalization. Thirdly, family members comment on the professionals' discourse. That is, after the reflections, one of the therapists invites family members and other network members to comment on what they have just heard.
11. Being Transparent. All discourse about care is shared with all participants. Everyone in the group meeting is equally involved in all discussions and shared information. This means that all views about hospitalizations, medications, and alternative treatments take place in the presence of

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everyone. Often, transparency manifests as a characteristic of reflections.

12. Tolerating Uncertainty. The main idea that professionals should keep in mind during crises is to behave in a way that increases the sense of security among family members and the rest of the social network. Among the specific practices associated with this idea, it is important to establish contact with each person immediately in the first meeting, then recognize and legitimize their participation. This recognition reduces anxiety and increases connection and consequently the sense of security. In addition, the availability of immediate meetings with the team and the frequency of them help the network tolerate the uncertainty of the crisis, as the group works on a shared understanding of what scares and distresses people. This shared understanding can give rise to new forms of intervention. In the same spirit, the starting point of a dialogical meeting is that the perspective of each participant is important and accepted unconditionally. This means that therapists must refrain from conveying any notion that our clients think or feel differently from their own. Nor do we suggest the idea of knowing more than is expressed by the meaning of what people themselves tell us. This therapeutic position is a paradigm shift for many professionals because too often we are accustomed to thinking that we should interpret the problem and come up with a solution that counteracts the symptoms, inducing a change in the individual or the family.

According to the vision of the Caltagirone group, Open Dialogue is not just a method or technique but a way of life, a daily attitude, a posture. It is remembered that "dialogue is something we cannot escape, it is there like breathing, work, love, hobbies, or driving a car. It is life." In fact, dialogue is the second act that humans perform at birth, immediately after breathing. "*As living beings, we are relational beings; we are born into relationships... Nothing is more necessary than being heard and taken seriously, and this is what gives rise to a dialogic relationship*" (Barone, 2020). During meetings, professionals aim to reactivate dialogue among family members, believing that the resources for care are already internal to the family itself and with the goal of proposing a new representation of the "problem" to the family. Positively reframed in every word, the language of the group seeking help is, therefore, "merely" returned to them transformed, with the aim of co-constructing a new one, shared with the care team from then on.

Thus, the Open Dialogue practice it is not about identifying "healthy" or "sick" individuals, winners or losers, nor finding solutions to problems, but opening up new perspectives and making new and visible possibilities, showing them through the polyphony of dialogue: "the challenge is to abandon our aim of producing a change in users through our interventions." Following an initial exploratory meeting within the Collective, the idea of organizing an online course emerged, in order to familiarize with the founding principles and theoretical apparatus. With the collaboration of the Luigi Sturzo Institute of Sociology, the "Intensive course of training and awareness-raising on dialogical practices in clinics and services: inspiring principles, methodologies, tools, experiences" was scheduled from April to December 2022 with experiential training on a monthly

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basis and theoretical insights through an additional FAD registered course, made available by the organizers.

After the end of this first intense experience, we discussed with some of the group members. The common feeling was that they had only "tasted" a bite of what could have been an extremely intimate experience, a true contact with the other. Based on these feelings, it seemed natural to many to see how everything they had heard was actually put into practice, in Caltagirone. In pairs, over a period of 6 months, the Collective visited the Department and shared deeply in the lives of the operators of the DSM Caltagirone-Palagonia, in a general atmosphere of welcome and generative exchange.

Conclusions

It is difficult to convey my experience at Caltagirone because it was complex and multifaceted, and any description must be simplified. Perhaps the pursuit of this complexity helped me relax; breathing is a result of this experience. We found ourselves in a world of shadows and problems, compelled to cope with complex situations that occur in all care settings.

The democratic and dialogical approach in Caltagirone emerges from a context that takes into account common difficulties in all areas (lack of psychiatrists, stigma, bureaucracy, difficulties in managing power dynamics), as well as those that are unique and contextual (such as the difficulty of reaching the CSM via public transportation for residents of neighboring villages). Nonetheless, the everyday labor in Caltagirone is distinguished by a consistent dedication to understanding people, listening to them without criticizing or giving advice, expressing one's experiences and emotions, and doing a continuous study of one's mood with complete transparency and sharing.

Meetings between professionals and users are focused in this way; every human interaction is treated with the same methodology. This makes me believe that empathy and mutual listening are the cornerstones of all therapeutic acts in Caltagirone, and that they should be the basis of any care tool. From a Sicilian perspective, the field of mental health encompasses therapeutic action beyond the medical-patient encounter. It also refers to the confrontational moment between operators, wherein ample and structured space is provided because they understand that the user's well-being is contingent upon the caregiver's and the structure's overall wellbeing.

This, in my opinion, is the greatest reversal I experienced in Caltagirone, in its simplicity. Furthermore, after the user has been acclimated to the standards of listening, professional secrecy, and first-person sharing, they can care for the caregivers while also caring for themselves. It is a virtuous cycle of care that feeds on itself, spreading to the user's network and, indirectly, the operator's.

Given the benefits, what prevents us from doing this even in places other than Caltagirone? It is difficult to introduce a democratic and dialogical tool into public mental health services that have long been built on asymmetric responsibilities and knowledge. How reassuring it is to know that as doctors, we cannot be questioned.

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However, I wonder how much alleviation and enrichment a professional practice based on ongoing confrontation with the figures with whom we work, as well as those who have first-hand experience, can provide. It is difficult to be vulnerable and to disclose one's feelings and insecurities; this is likely the source of the most distrust. However, taking even a modest step demonstrates how important it is, primarily for the well-being of people who eventually wield power.

Among the many intriguing views, I take away a line from Professor Barone: "revolutions are useless, reforms are necessary." I return home with the knowledge that, beginning tomorrow, I will be less afraid of believing that something new may be created,gradually, while keeping the Caltagirone experience in mind. Furthermore, I will be less afraid because I know there is a place where we can work together to listen to all of the figures surrounding mental health, and that we are progressively building a network of operators based on strong emotional relationships.

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