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Essay

Psychotherapy as a Polyphonic and Playful Conversation

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Abstract: Since the emergence of hypnosis, we have witnessed a multiplication of psychotherapies, which have different backgrounds and aims. The omnipresence of psychotherapy leads us to an inevitable question: what is psychotherapy? In this article, we analyse the concept of mental disorder and how psychotherapy works, underlining three mechanisms: influence, polyphonic dialogue and play. Focusing on the therapeutic dialogue, we explore what is told during therapy and how, what is done while telling, and how dialogue can create new narratives and new meanings, highlighting the importance of influencing the patient on changing the symptomatic behaviour. We also consider how the multiple voices of the patient, therapist and others can generate an alternative to the monologic discourse of the disease. While the psychiatric illness may indicate a sterile dialogue which often expands the pathology, communicating in a different and active way can create new and healthier meanings. Therefore, one of the therapy's aims is to influence the patient, throughout a dialogic and playful conversation, to gain freedom from disease.

Keywords: psychotherapy; polyphony; dialogue; Bakhtin; play

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1. Introduction

The relationships between guidance, mastery, examination of conscience, meditation and counselling have been present since Antiquity, for instance in the relation between the shepherd and his flock, the master and his pupil, and the doctor and his patient [1]. Psychiatry has incorporated some of these practices and, since its inception, words and the relationship between the patient and the therapist have played an important part in treatment, which gained autonomy under the concept of psychotherapy. Since the emergence of hypnosis [2], we have witnessed a multiplication of types of psychotherapy, which have different backgrounds and different aims, such as the knowledge of the self, its control, transformation or change [3]. The omnipresence of psychotherapy leads us to an inevitable question: what is psychotherapy? Different answers could be proposed: it is just a conversation or a well-developed group of conversational practices; it is a complementary or an essential practice; it treats suffering or it treats diseases; it is a normative technology; or it increases the patient's freedom. A possible answer such as "psychotherapy is an efficacious approach for the amelioration of psychological distress a and improvement of functioning" [4] has the advantage of including other therapies besides talking ones, such as music therapy, body movement therapies and art therapies. In this article, we focus our analysis on conversational therapies. In response to the question of what psychotherapy is, Jay Haley [5] argued that "in the last few decades we have seen the social impact of therapy developing everywhere in communities, and we can no longer think of therapy as simply the interchange between two people. It is a business, a calling, and the agent of many forces".

Despite their numerous differences, most psychotherapies share certain aspects: the importance of communication, the relationship between doctor and patient, and its occurrence in a therapeutic setting. Jerome Frank [3] identified the common features to all psychotherapies which include: providing an intense, emotionally charged, confiding relationship with a helping person; a rationale, or myth, which includes an explanation of the cause of the patient's distress and a method for relieving it; provision of new information concerning the nature and sources of the patient's problems and possible alternative ways of dealing with them; strengthening the patient's expectations of help through the personal qualities of the therapist; provision of success experiences which further heighten the patient's hopes and also enhance their sense of mastery, interpersonal competence or capability; and facilitation of emotional arousal. The existence of a healing setting which is simultaneously a safe space, the place where a ritual occurs, a symbol and part of the power of the healer, is also a determinant aspect [6]. Overall, psychotherapy can be a specific form of interaction (verbal or not) that exists in an environment of therapeutic intervention. This statement leads us to a second question: do psychotherapies work, or is their work based upon processes of spontaneous change and not upon therapeutic actions?

Firstly, we would have to dwell on what psychotherapeutic work is. There is not a unique answer. Research has shown that factors associated with the results of psychotherapy include: the patient's characteristics such as motivation and social support; treatment aspects, namely model and technique; the therapist's attributes such as alliance and relationship between therapist and patient; expectancies, placebo, and allegiance effects [4]. Regarding therapists, Bruce Wampold [7] considers that effective therapists have a sophisticated set of interpersonal skills, make the patient feel understood, are able to form a working alliance with a broad range of people, provide an adaptive explanation and a treatment plan for the patient's distress, are influential and flexible and monitor the therapy's progress. However, even with well-trained and supervised clinicians, it is estimated that a significant percentage (30% to 50%) of patients do not benefit from therapy [4]. Secondly, while most evidence-based medicine and neuroscientific studies demonstrate that psychotherapies improve the patient's mental health [8–10], not only does this not deny that this improvement could have happened otherwise, but there is not a consensus about explaining how psychotherapies work and what makes some conversations better than others.

Starting from previous contributions to dialogical approaches in psychotherapy, from existentialist perspectives [11,12], to sociometric [13], systemic/narrative [14–16] or dialogic/polyphonic [17,18], we aim to add new ideas that can be brought to an old conversation. By drawing from these different contributions, we want not only to build upon previously existing knowledge, but also encourage the natality [19] and plurality of new psychotherapeutic techniques. Focusing on the therapeutic dialogue, we will analyse what is told during therapy and how, what is done while telling, and how dialogue can create new narratives and new meanings, highlighting the importance of influencing the patient on changing the symptomatic behaviour more than understanding its causes [20]. The idea of a polyphonic dialogue, proposed by Mikhail Bakhtin [21], is an unfinished and never-ending dialogue, which emerges from different voices. In therapy, we will consider how the multiple voices of the patient, therapist and others will generate an alternative to the monologic discourse present in the disease. Jaako Seikkula [22] highlights that "There were always many voices present in the treatment meetings and, as Bakhtin notes, in a polyphonic meeting the position of every participant, especially the author, is changed radically. The only way to proceed is to generate dialogue between all the participants' voices, and in this polyphony no voice can be more important than others". In contrast, the monologic discourse of the disease is centred on symptoms and is usually monothematic. Although it intends to be scientific and real, sometimes it is so closed that it prevents alternative and healthier dialogues. In addition, it also keeps the person tied to the patient role. Frequently, this is a discourse shared by the therapist and the patient. A different dialogue, including multiple perspectives, that intends to be playful, challenging and trigger new

understandings can also promote new subjectivation processes and new roles that should be multiple and polyphonic [23].

2. Methods

In this article, as we cannot inquire about what psychotherapy is and does without first thinking about the one-million-dollar question "what is a mental disorder?", we start by analysing the concept of mental disorder. We think about the differences between mind and body, the loss of freedom caused by the disease and the impact of the symptoms in the communication. Afterwards, we focus on how psychotherapy works, highlighting three mechanisms that we consider essential to it: influence, polyphonic dialogue and play.

3. Results and Discussion

3.1. From Disease to Therapy

The concept of mental illness is probably the most discussed in psychiatry. While in the past it excluded organic diseases previously identified as psychiatric such as epilepsy, in recent times, the organic aetiology underlying mental disorders is becoming more relevant [24]. This can be seen, for instance, in the case of the recently created Functional Neurological Disorder, which corresponds to the old Dissociative and Conversion Disorder, which in turn corresponded to the even older Hysteria [25]. Not ignoring the social and political aspects that constitute mental disorder, in this article, we discuss three aspects: mental diseases are also diseases of the body, communication has an impact on the disease and the disease reduces the freedom of the subject.

In his book *The Myth of Mental Illness*, Thomas Szasz proposed that all diseases are body diseases and that mental disorder is the result of a dysfunctional communication [26]. To accept Thomas Szasz's claims is not to deny the existence of mental disorders, but instead to reaffirm them in the context of a body that is simultaneously mental and corporal, human and non-human, real and virtual [27]. Recent proposals try to overcome the body and mind division, avoiding reductionist approaches, and intend to capture the complexity and integration of multiple processes connecting body, mind and environment [28,29].

Besides, it is well known that symptoms have communication value. For instance, conversive symptoms are a way of "body talking" when the expression of thoughts and feelings through speech is not possible [30]; psychosomatic disorders are related to alexithymia [31]; delusions can be understood as another kind of communication and are not deprived of meaning [32]. Furthermore, the disease can result from and has an impact on the patient's relationships, and communication can contribute to perpetuate or extinguish its symptoms [33]. Although a symptom is an inflexible and repetitive behaviour, feeling or thought, the appearance and persistence of the disease can only be understood if we also recognize its advantages, such as: control of the relationship, avoiding dangers, keeping the family together, or to give meaning to some experiences. However, this is a maladaptive answer as it causes more drawbacks than benefits and reduces the freedom of the patient to act or feel in other ways.

The relationship between health and flexibility was proposed by Georges Canguilhem [34] who defended that there is the normative, which means variability and flexibility, different from the normal, which is the statistical average. While health is normativity, pathology is a reduction in this flexibility. In the same way, disease causes an acting rigidity that captures the subject. Therefore, its treatment should increase the freedom of the subject. The idea of freedom of choice has been appropriated by the liberal discourse of autonomy, empowerment and agency. However, what we would like to propose is freedom to behave, think and feel in a different and healthier way or, in Foucaultian language, an ethics of freedom as a care of the self [35]. An autonomy that does not need to make the patient more functional or productive, but that fits better into their own values and desires. We do so by proposing a psychotherapy that creates ambiguity and new levels of language, and whose main characteristics are: hypnotical, dialogical and playful conversation, which we will now elaborate in more detail.

3.2. Under the Influence

Carl Whitaker [36], at the First International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy in 1980, affirmed that there are hypnotic processes in our childhood by which our parents prescribe our character structure. For him, one of the strengths of psychotherapy is its power to "undue" this family influence, namely through the recapitulation of the childhood hypnosis, the freedom of approaching or moving away from these prescriptions and the developing of an ability to metacommunicate about them. In this vein, we can look at hypnosis as something that is present in our relationships and that, in therapy, can be used not as a way of suggestion, meaning a way of imposing something on the individual from the outside, but instead as a way of influencing and activating the healthy factors that are within the person. The narrative of the disease is generally a very hypnotic device for both the patient and the doctor. In the doctor–patient relationship, both play their roles, describing and identifying symptoms, which may create the history of the subject in a pathologically oriented way [37]. Usually, the patients arrive with "story-types" that reproduce the general narrative around the diagnosis, which further reinforces it in a looping effect between classifications and classified, and between patients and doctors [38]. If, on the one hand, that "looping effect" can be useful in helping both patients and doctors coming to a diagnosis, on the other, it can also perpetuate the symptoms. According to Milton Erickson and Ernest Rossi [39], hypnotherapy is "a process whereby we help people utilize their own mental associations, memories, and life potentials to achieve their own therapeutic goals". Hypnotic suggestion can facilitate the utilization of abilities and potentials that already exist within a person but that remain unused or underdeveloped because of a lack of training or understanding. Through a hypnotic conversation, psychotherapy should be able to create new stories, new meanings, activate the subject's curative factors and help him in un-hypnotizing from the disease. As defended by Narrative Therapy, one of the desirable outcomes of therapies would be the generation of alternative stories [40]. Such stories would begin from elements which both the patient and the family brought into the therapy [41]. They would incorporate vital and previously neglected aspects of lived experience and knowledge, emerging as alternative and non-conventional narratives. Moreover, these narratives are not only speeches but also alternative performances, incorporated through a dialogical relationship. Here is a possible example of this approach in practice, taken from the beginning of a consultation:

Patient: I am sad and depressed, I even cried last night.

Therapist: Where were you, while you were crying?

P: Alone in my living room, watching TV . . .

T: What were you watching?

P: The soap.

T: What was this soap about?

P: About a mother that earns that lottery, it is a really funny soap . . . I usually don't watch soaps . . .

T: What made you watch this one?

P: Because the mother is really struggling to help her children, but everything is always going wrong for her.

T: And what would you do if you won the lottery?

What can at first seem dismissive of the subject's feelings is in fact a way of moving the patient towards talking about other experiences and feelings that are also meaningful to his or her life. In therapy, the patient and therapist agree to collaborate, so they accept that they will influence each other. Meanwhile, like all relationships, this is an asymmetric one and, even though the responsibility is shared, the therapist has the responsibility to lead the therapy and to try to release the patient from the disease's spell. The question of

how much responsibility the therapist should acknowledge depends upon the particular patient before him and not upon a general rule [20]. A rational approach—one that searches for causes and prescribes behaviours—is not always the best therapy Talking about Milton Erickson therapy, Jay Haley [20]) says: "change could occur without people having any understanding of why they had the problem or how they got over it. It was his willingness to change someone without teaching them the cause of the problem that was most typical and most opposed by the therapists who believed that only self-knowledge leads to salvation". Oftentimes, rationality can be the cause of the symptoms [42]. Taking a different stance through multiple dialogues and voices would be an integral part of psychotherapy, and something that we will further address in the next section.

3.3. Speaking in Tongues

There are a significant number of songs that talk about silence and miscommunication. In the song *Medicine Bottle*, from *Red House Painters*, the narrator of the song tells the story of a girlfriend who says to him "*it's all in your head*" and later, he confirms that "*is all in my head*". That is an expression commonly used by patients in the clinical practice, and most psychotherapies that try to know and explore what is inside the patient's head [6]. However, what if a therapy dwells more on what is outside of the head, namely on what the patients say, than on what is inside the head? One of the aspects that create our subjectivity is what we say about ourselves, which is heterogeneous and results from multiple voices and influences. Analysing Dostoyevsky's novels, Mikhail Bakhtin [21] says that their characters represent a particular point of view which is not monologic or closed but in which self-conscience emerges through its unfinalizability and indeterminacy. Contrary to the determination of psychological laws, the characters are created in a polyphonically and dialogical way. This unfinished dialogue underlines the fact that any speaker is himself a respondent, they are never the first speaker as they are always responding to their culture, family and within political devices. Moreover, these polyphonic dialogues are made by utterances which, contrary to sentences, are active parts of speech that lead to an answer [43]. Even if it is the same sentence, changing the subject transforms the sentence into an entirely new utterance, as it assumes new qualities [44]. Based on these insights, psychotherapy should be understood as a dialogue made by utterances that always ask for an answer, and not for long and closed speeches [45]. Repeating the patient's words is a new utterance and asks for a different return. Like in jazz music, there is an improvisation when these utterances are played off one another. Both patient and therapist communicate in an active way that requires an answer and creates new meanings, as a way of producing a new and polyphonic subjectivity. Several questions arise immediately: is the structure more important than the content? An answer to this question would be that there is a rhythm whose presence is essential for a dialogue to become fruitful. This rhythm is created during the therapy between the patient and the therapist. The contents are part of the game, they are ideas that are put into play while we are playing.

Comparing magical healing and psychoanalysis, José Gil [46], a Portuguese philosopher, analyses a situation, previously described by Levi-Strauss [47], where a shaman's song leads a patient who is struggling to deliver her child and helps her through the process, manipulating her organs with language. In this case, more than performing a symbolic function, language causes/induces the patient to have an altogether different experience while giving birth, as a result of the ritual, the words and the rhythm of the shamanic song. What happens is as a sort of enchantment, and a similar kind of phenomenon occurs in therapy. For José Gil [46], language will have a corporeal effect and cause a body experience that escapes the persons' awareness, or at least is a different kind of it. Two modes of communication are proposed: the literal and the metaphoric. The schizophrenic language is an example of pure literality, whereas an example of the metaphoric use of language would be that of therapeutic narratives, folk tales and myths [46]. In therapy, the use of metaphors can create new meanings, and the therapist should play the game and accept the nonsense. Carl Whitaker defended the use of absurd, challenging and "crazy"

interventions, arguing that therapy should increase the complexity of the situation, and induce chaos and craziness, rather than restore order [48]. For example, a patient with schizophrenia, who has a filiation delusion believing that he was adopted, said "*my father wants to make love to children*", during a therapeutic session: Taken literally, this means that his father was a paedophile and that probably this was a delusional idea. Through a dialogical therapy, words are exchanged and their meaning can be recreated in another way. During the conversation, a more benign idea emerged: his father loved children. Naturally, subjects are all different, so the strategies should be adapted and used with spontaneity. Next, we present two examples of different moments in therapy sessions where the therapist is trying to bring other voices (and meanings) into the conversation. The first one is about a patient that has insulted her mother during a crisis.

P (crying): I was feeling really bad and she didn't help me, that was why I became angry with her.

T: What you would have liked that your mother did?

P: Hug me.

T: How would the hug be like?

P (stops crying and smiles): A very strong one.

T: And there is something more that you would have liked your mother to do?

P: I would like her to teach me things.

T: Like what?

P: To cook!

T: What you would like to learn to cook?

P: A plate with rice and beans! A chocolate cake!

T: You are insatiable! Can anyone teach you this besides your mother?

P: Maybe my boyfriend.

In the second example, the patient is having suicidal thoughts and is feeling more depressed again.

P: I feel miserable, I'm depressed and I am suicidal, it never stops, I am always crying and I don't want to see anyone . . .

T: And did you see anyone?

P: In the weekend, I went to a birthday party.

T: How it was?

P: It was ok.

T: What did you like about it?

P: People treated me really well.

T: How?

P: They were very happy to see me, they say that I have very strong opinions and that they have missed me. And, what I like the most, they say that I'm very skilful with children.

T: What are your thoughts about that?

P: They have a point, I really know how to engage with children. I felt really well there, playing with the youngest, having fun and people recognizing my skills.

T: Did you already know that about yourself?

P: Yes and no . . . but when I arrived home, I felt a like a looser again, I just wanted to die, I had a crisis and I am worse than ever since then.

In the first case, different ideas about the relationship with the mother emerged, and even about the boyfriend, while in the second case, the speech of the disease returned. One hypothesis is that the narrative distanced too much from the story that what was initially brought by the patient. The right movement should be one that, although not trying to balance different narratives, is grounded in the patient's initial narratives. It should add new layers of meaning, creating sufficient ambiguity to make the previous narrative and its behaviours impossible. During the course of therapy, the therapist has to keep the ball constantly in play, in order to keep the patient engaged. If the patient loses interest, the ball drops, the game is over, and the disease wins. It can be very helpful to have a healthy conversation about patients' interests, more than symptoms. For instance, a patient who was very sad when talking about her hallucinations and suicide intentions had her mood change completely when she started talking about her grandson, but if the doctor had not intervened or seemed dismissive about this second history, the hallucinations would have returned again to the conversation. By maintaining an impasse in the speech, in refusing to offer quick exit strategies or conventional solutions, the therapist opens avenues for paradoxical dialogue in which different meanings can be explored at the same time, and through which new ways of creating oneself in a healthier way can emerge. Throughout this article, we have talked about the importance of therapy as a game, which is something we will explore more deeply in the next section.

3.4. Play It Again, Sam

Psychotherapy should be lively and playful [33], or, to quote the title of David Foster Wallace's book, "*A Supposedly Fun Thing I'll Never Do Again*" [49]. It should be similar to a game, played between the therapist and the patient, where the possible outcomes could be pain and tears, but also joy and laughs. From its beginning, the importance of action in therapy was recognized. John Austin [50] defended that some speeches are actions or parts of actions that actually do something, rather than "just saying something", which he named speech acts. Jacques Derrida [51], who reflected upon the ideas of John Austin, also wrote about constative and performative utterances. While the constative utterances give information, the performative utterances do things while speaking. He gave confessional speech as an example of performative utterances, due to the transformation that occurs during confession. Additionally, in therapy, words are not only informative but can contribute to changing the subject towards being a healthy person again. If we think about children's development, children learn language by playing and through interacting with others [52]. In the same way, psychotherapy should be a talk that makes things, that needs action and spontaneity, and where patients can have a new experience. Jay Haley [20]. affirms "A key factor in understanding Erickson's therapy is to realize that he does not assume therapeutic change occurs as a result of more awareness or knowledge in the usual sense. He does not teach the patient what he should know. Instead, he arranges a situation which necessarily requires new behaviour from the person and consequently a different experience of living." We return here to the significance of the body, highlighting that the incorporation of this experience could be more important than its rational explanation. The therapist should play the game, keep the ambiguity, know how to change from seriousness to a playful tone, and accept the nonsense and craziness of our language. For instance, a patient says *"Yesterday I thought about killing myself by taking a box of pills, like I have done several times before. I didn't do It because it took too much work coming to the hospital and having my parents worried"*; the therapist could ask *"What made you think that it was worth it all those other times but not this time?"*. This does not mean that the therapist is ignoring the patient's suicidal intentions, but instead that those intentions can both be taken seriously, but also as words. Another example is about a patient that is very isolated and that, during the consultation, says "*I have been thinking, I am not expecting that you agree with my idea, but maybe I can be a sexual worker, an online one, I don't like to leave the house so this will be a perfect solution*". To this utterance, there are several possible answers: *"what a great idea!"*, *"I totally disagree, it does not seem a solution to your problems" or "are you sure that this will work?"*. The

last option tries to create ambiguity, taking what the patient is saying simultaneously in a serious and a provocative way.

Like a game of tennis, the first player hits the ball, the second replies, and the way that the second player hits the ball back will make the first player move accordingly. Unlike tennis, psychotherapy is not a competitive game, so there are no aces. The aim is not to win, but to delay the match point and keep playing. Whomever has watched tennis games knows there is always a rhythm going between the two players. The rhythm changes throughout the match—sometimes slower, sometimes faster—and is an essential part of the structure of the game. It is a sort of a relationship between the two. When two players are playing together for the first time, the rhythm is established in the moment, as they get to know each other, anticipating their moves and trying to surprise the other player. Getting to know the other player has advantages: we find it easier to get back into the rhythm we established last time, which in turn enables us build from that rapport and improve the overall level of the game. Such is also the case in therapy. Coming to know the patient also brings additional therapeutic benefits, obviously: it allows us to develop a relationship of trust and stability, something that is often lacking in our patients' lives; and having a healthy relationship is in itself helpful, namely in developing a sense of trust in the world [3]. However, there is always an underlying risk between hitting partners that have come to know one another all too well: the danger of becoming too complacent and comfortable in the game. If this happens, the other player, the patient, will lose interest in playing altogether. To counter this, the therapist should consider using surprise as an integral part of their game plan. Surprise is not to be used to declare victory or defeat, but to create new movements which will keep the game challenging for both participants and keep the dialogue going.

4. Conclusions

In this article, we analysed therapy as a conversational practice that occurs in a therapeutic setting and that addresses significant factors of mental disorder: vicious communication and lack of freedom. Based on significant authors such as Milton Erickson, Carl Whitaker and Jaako Seikulla, and adding our own perspective and clinical examples, we opted to focus on practices that specifically deal with these aspects such as influence, dialogue and play. The psychiatric illness or symptom can indicate a sterile dialogue, which expands the pathology and, in a sense, is monologic. This means that it is blocked in one perspective. It is a monologue shared between two or more persons. Although several persons are talking, there is only one underlying speech. The reasons for these are variable and include: the speech of the disease is so loud that it supresses the others, the patient cannot leave the disease narrative or the therapist is not able or does not want to challenge this speech. A polyphonic dialogue should include the different voices of the patient and other "players", namely their memories, cultural background, different narratives, ideas and feelings. The idea is not to clarify these voices but to aid more voices and more chaos to combat the absurdity of the disease. The difference between voice and perspectives is that these voices are not only rational, cognitive or thoughts but are also emotional and embodied.

One of the aims of the therapy that we defend is to influence the patient, throughout a dialogic and playful conversation, to gain a space of freedom, which means freedom from the handcuffs of the disease. This should be carried out with the patient and according to what they want. Naturally, this raises some ethical questions, namely what is best for the patient. Psychotherapy is not free of risks, and an excessive attunement between the therapist and the patient can cause the emergence of a unique language and preclude other possibilities of subjectification. We also consider that mental disorder is a historically situated concept, so mental health could also be considered the better adaptation to a social and political context. The super-healthy subject would be the super-adapted one. Although it is impossible to avoid the political influence on psychotherapies, the therapist should be attentive to not force the subject into pre-written narratives of power and functionality.

There is not a previous truth about the subject that we need to know in order to become healthier. There are stories, powers, meanings that belong to the subjects' biography, from which new stories, powers and meanings can emerge. In other words, the subjectification processes are multiple, some of them emerging during therapy and that can open new possibilities of subjectification instead of reducing them. Besides, one of the most important risks of therapy is contributing to the reification of the subject as a patient. Influence is always a balance as is responsibility. Regarding the non-collaborative patient, when the patient is aggressive or at risk, the therapist may need to assume a monologic stance. Sometimes, the safety of the patient is the higher value in play. However, even patients in acute psychosis are able to participate in dialogue [53].

We do not aim to be monologic ourselves and say that only these techniques work. They are based on insights from other authors and psychotherapy models, and in some situations, a more rational and teaching skills approach than the one we advocate is also helpful. We consider that techniques such as improvisation and a not-knowing stance are significant, but due to a lack of space, we chose not to address them in detail in this article. There are also other non-psychotherapeutic practices that can play a role in improving our mental health and, returning to the initial question, the subject may change by himself and by other experiences outside the therapeutic range. Finally, we expect to stimulate better psychotherapeutic practices and to promote new conversations about psychotherapy.

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