CULTURAL ANTHROPOLOGY

Colloquy

SYMPATHETIC CARE

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Seven trainees sit in a circle, while the voices of the other groups ricochet around the vast space of the aged meeting hall as they find their practice rooms. Gradually, doors close, the noise settles. The group sets up a role-play exercise: there are two moderators, Patrick and Elke, and two members of the reflecting team, Sara and Hanna. The remaining three—Otto, Marthe, and Anne—take on the roles of family members. Otto volunteers to be "the person of concern": drawing on his experience working with a client in the hospital clinic, he will become that client, and create additional familial roles based on real people for Marthe and Anne. To begin, Otto describes himself as the client, whom he decides to call Daniel.

> I am twenty years old, I have a problem with alcohol. I lost my brother, he was twenty-one and I was seventeen when it happened. I learned how to drink from him. Now I am using pain medication, drinking alcohol, and smoking cannabis. I am working as a janitor; my professional training has been put on hold. (Otto as Daniel)

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Erich, their trainer, instructs Otto to give the other family members their roles. The others listen to his descriptions of their relationships to Daniel; Otto tells them who they are and what kind of relationships exist, drawing on his memory of Daniel's family constellation from their clinical encounter.

> Stand up behind her, put your hands on her shoulders. Speak to her, not to us, this makes the connection to the role deeper. (Erich as trainer to Otto as Daniel)

> You are my mother, you are very sad. Your first child is dead, and now you worry about your second son, who has been in the hospital. I still live with you, as well as with my girlfriend. You are very accepting, overbearing at times. My father is a mystery. (Otto as Daniel to Marthe as Mother)

> You are my girlfriend, Paulina. We have been a couple for one and a half years. You are critical of my alcohol use, and this makes me drink more. When I drink you won't talk to me, and you leave. You are nervous when I am drunk, but you always come back. You love me. My mother gets it, you have a good relationship with my mother. (Otto as Daniel to Anne as Paulina)

Daniel is presently an out-patient client, but he has spent time on the in-patient unit. In the context of the role play, Patrick, Elke, Sara, and Hanna act as if they are clinicians coming into Daniel's mother's home, and they introduce themselves to each of the family members, shaking hands, making eye contact, exchanging names. They take their seats. Erich reminds them of the fundamental principle they have been working with for months now: "Repeating key words can make space for stories that are not yet told. Single words, which may be mentioned only briefly, but which feel important, can give access to deeper experiences in the past. Often it is enough to just repeat a single word." Then Daniel, as moderator, begins . . .

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This role-play exercise forms part of the training for Open Dialogue, a treatment model for psychiatric crisis that aims to keep people out of the hospital and connect them to their social and familial networks as co-participants in that process (Olson, Seikkula, and Zeidonis 2014). It refrains from using diagnostic categories and traditional psychiatric language, aiming to reduce hierarchies

of expertise and the preemptive authority of clinical accounting. To learn Open Dialogue, trainees (who are often already trained as psychiatrists, psychologists, nurses, or social workers) are asked to take on the roles of clients and their family members, and to find their way to a particular kind of listening: one that backgrounds clinical authority and the impulse to care through recommendation and crisis resolution. Trainees are urged *not* to listen for symptoms, or with the goal of interpretation or diagnosis. Instead, they are taught to create space for silences, allowing for moments into which previously unheard stories of the family network might emerge, provoked by the careful repetition of single words. This account of the trainees I worked with at a German psychiatric clinic offers an exploration of the affective anxiety that characterizes this learning process, and the means by which imagined relationships between absent clients generate a reconfiguration of the clinical self (Hacking 1986). This self is responsible not for repairing relationships, but rather for interrupting the potential *misalignment* of relationships though the use of *sympathetic care*: a practice of discernment attuned to subtle shifts in resonant experience and the co-construction of shared meanings.

Clinical characterizations of care often describe the desire to help, to better, to improve, or to correct (Tronto 1994; Stone 2000; Buch 2013). This commonsense approach to caring hopes to alleviate suffering (Kleinman 2010) and, in the case of acute psychiatric distress, to offer an interpretation of chaotic events and possibilities for resolution (Luhrmann 2001; Hejtmanek 2015). Contrary to common clinical practice, the caring self cultivated to do the work of Open Dialogue is rather subtle; it requires an intense kind of presence, yet it does not always need to speak, and can seem, at times, almost like doing nothing at all. It demands the persistent attention Annemarie Mol (2008) describes in her "logic of care," but it refrains from the interventionist attitude that accompanies her notion of "tinkering." It aims to create a space apart from the future-oriented promises that typically infuse biomedical approaches with reparative aims (Jain and Kaufman 2011) and, instead, offers *sympathetic care*. Sympathy in this case does not mean pity or the benevolent recognition of suffering, but rather an attention to the co-construction of present moments and an embodied attunement to the experiences of others (Bergson 2001). Sympathetic care works by discerning through contemplation the nodes of the social network that might be therapeutically shifted: "Sympathy as the motor of excavation allows the movement to be felt, opens experience to the complexities of its own unfolding" (Manning 2016, 50). Sympathetic care asks clinicians to attend to the density of intersubjective relationships, as well as to the

affects that emerge in response to the disturbance and recalibration of those relationships through processes of fracture and resonance.

Learning to tolerate sympathetic care does not come easily for this professional group; to let go of well-honed clinical authority and attune themselves to a kind of resonant listening can prove profoundly uncomfortable, and novices often project their discomfort onto the imagined clients and families. They ask questions like, "But what do we do when the family wants an answer?" acknowledging that the expectation of clinical authority does not just emanate unidirectionally from clinicians but is also something families have learned to expect in clinical encounters. Clients often come to Open Dialogue not knowing what to anticipate; it is still considered a marginal approach, and families may never have heard of it before it is offered to them. Often, Open Dialogue is offered to clients and families who have tried everything else (medication, hospital stays, systemic therapy, rehabilitative programs) and find themselves at their wits' end. The Open Dialogue training asks clinicians to share this state of unknowing with clients, directly acknowledging rather than obscuring the fact that clinical intervention can often seem futile (Brodwin 2011). The clinical team is taught to believe that the family possesses its own solutions; its members just need moderators to help them identify misalignments.

In the role-play exercise, trainees assume the identities of real people, but apart from the setup, they make those roles their own over a ninety-minute improvisation that parallels the ninety-minute structure of an actual network meeting. The clients they impersonate are not actively present in the room (nor have they explicitly consented to being referenced in this context) when the trainees work to imagine new ways to listen to them. Ethically, trainers see the use of real clients as permissible, given the use of pseudonyms and that the relations they act out are not meant to replicate the dynamics of the family. But beginning with an actual network gives the exercise a more palpable reality than a completely fictional premise, and the preparation is designed to make this role feel real. Thus Erich's instruction at the beginning of the scene to touch the other person, and speak to her as a family member, creating an embodied sensibility that attunes to family history without requiring the clinicians to *actually* share one. As a result, the therapeutic referent slips between those experiences that clinicians imagine as belonging to the client and the personal experiences by which they can possibly imagine a similar situation (Hollan 2008). Before going into this particular role play, for example, Otto (playing the person of concern) told me that he was utterly terrified: "You never know what's going to happen in the role play," he explained,

laughing nervously and fidgeting with his hands, "but this is good, because this is the same feeling that happens when you work with the client, and which you have to imagine is happening for the client and his family as well." By speaking as the already-absent client, what the trainees are actually working on is a reconstitution of the professional self as an active listener. They look for familial cues, for the traces of a family history in what is technically an ahistorical situation, and struggle for an understanding of therapeutic effort that is more sympathetic than corrective to those traces.

* * *

I am very worried about my son. His brother died in the clinic. ("Mother")

I am afraid, as your partner, that alcohol is more important than I am. ("Paulina" to "Daniel")

I wish that he would find a job. ("Mother" to the group)

I have a job, I know it's not great, but it's a job. I have to get up early, which means I drink less. You wish I had more hobbies, that this would help, but I disagree, I am already *belastet* [fraught, burdened, stressed, strained, weighed down]. ("Daniel" to "Mother")

Belastet? (Elke as moderator repeats "Daniel's" last word back to him)

I miss my brother. He was my best friend. It's been three years now since he died. ("Daniel" to Elke/group)

I believe that Daniel is always drinking because he is sad, because his brother died. ("Paulina" to group)

Elke, as moderator, moves to interject, offering a suggestion. Erich stops her, "Don't interpret, don't try to clarify for them, you must do less." Elke is quiet, and Paulina speaks again.

There is no room to be sad, you drink and you don't notice how sad you are. ("Paulina" to "Daniel")

* * *

When Elke pauses and says to "Daniel," "*Belastet*?" she returns his word to him wrapped in a new frequency, with an unfamiliar vibration for him to feel. He listens to it and can uncover something not yet said in response: "I miss my brother. He was my best friend." By echoing the word in this way, Elke prompts the network, including "Daniel," to reconsider what it means to be *belastet*—to listen to the living sibling's drinking *differently*, and to contemplate that missing his brother exists at the same time as do concerns about his relationship and his job. Drinking is not only something that limits his professional prospects, or matters more to him than "Paulina," or worries his "mother." It can and might be all of these things, *and yet it is also* the way that "Daniel" actively misses his brother. Because Elke has repeated *belastet*, a moment emerges for the group to consider what this word means to each of them, and that there are different understandings and histories of being *belastet* that each of them carries.

This is the group's first full-length role-play exercise. They have practiced constitutive moments in briefer exercises, but their performance here is far from perfect. In fits and starts they struggle to *hold* silence; they remember not to interpret a statement *a split-second after* having offered an interpretation; they miss what Erich identifies later as additional key words that could have been repeated back. The emphasis on the single word becomes complicated here: the word can trace past experience and has the potential to presence unheard stories; at the same time, trainees are taught that the word is protean, that there is no single referent. The repeated word acts as a trace of the life it has led for the individual who utters it, and repeating it—shifting the register from something internally produced to something externally received—changes the tenor of the word in a way that can shift the arrangement of the group's component parts. Signaling the simultaneously shared and divergent meanings of *belastet* reveals anew that language is always relational. The fresh exposure of this fact is understood as therapeutic, in that it can open the path for new relational configurations.

The repetition of the word in this case acts as a minor gesture. Erin Manning writes:

> The minor gesture emerges from within the field itself: it is a gesture that leads the field of experience to make felt the fissures and openings otherwise too imperceptible or backgrounded to ascertain. A minor gesture is a gesture

> that tweaks the experiential to make its qualitative operations felt, a gesture that opens experiences to its limits. (Manning 2016, 83)

According to Manning, the minor gesture *activates*, and in this context, it surfaces the different meanings *belastet* has for each of the participants, the multiple ways that burdens and stress have made themselves felt in their own lives. Until *belastet* is repeated, and the change in resonance, from speaking to listening, is felt, "Paulina" and "Daniel's mother" may not have realized that the younger brother's burdens differed from their own, or their own conceptions of his.

Words come with their worlds: they bring with them every instantiation, circulation, and communication that has come before and carry these into the present. Words have lives: "The life of the word is contained in its transfer from one mouth to another, from one context to another context, from one social collective to another, from one generation to another generation. In this process the word does not forget its own path and cannot completely free itself from the power of these concrete contexts into which it has entered" (Bakhtin 1984, 202). Whose word is *belastet*? Does it belong to Otto or to "Daniel"? Does it matter? The word resonates across the muddled relationship between caregiver and receiver in the role play and informs the way Otto will listen to a client in the future. Elke encounters her own history of the word by being quiet, by correcting the impulse to offer an explanation. The focus on words reveals that no singular narrative exists by which clinicians, clients, or families can make sense of crisis, and the vulnerability of infusing the role play with trainees' own experiences is an embodied lesson in rendering clinical assessment less certain. They are learning not to offer any kind of positivist interpretation, but to interrupt perceived misalignments, and to see that only by diving into this misalignment the family can reconfigure itself. But the clinicians are not doing the reparative work themselves; they are only sympathetic to it. What initially seems like *not caring* is newly understood as a kind of humble accompaniment: "Contemplation is passive only in the sense that this attention provokes a waiting, a stilling, a listening, a sympathy-with. This sympathy is enveloped in the process, sympathetic to the ineffable share of experience emboldened by the minor gesture, attuned to the fragile arc of time" (Manning 2016, 62). To embrace what is offered as therapeutically valuable in this approach demands that trainees learn to sit with the affective tension of process, and with the slow excavation of familial traces.

Lispeth Lipari (2014, 102) recommends a type of listening "understood as a kind of dwelling place from which we offer our hospitality to others." This mode

of *listening being* "interrupts our habitual conceptual systems" and invites us to "step outside the quotidian order of things. Invested wholly in the present moment, it opens a space of being in which we may hear things not otherwise audible: the absent, the broken, and the radically strange" (Lipari 2014, 103). In like manner, Open Dialogue also "refuse[s] to control or master," exerting only a "light hold" on the conversation (Lipari 2014, 103), and so, over the course of their year-long training, repositioning the clinical authority that trainees are slowly divested of. To let go of the need to *fix* the family, to *ameliorate* the crisis, or to provide a *return to normalcy* constitutes a very different kind of care, one less about intervening to repair and more about tolerating the discomfort that forms part of not knowing how a crisis will resolve. The trainees learn to care about Daniel and his family by taking on their roles with each other and feeling their own lived experience of disorientation through improvisation within them. Care becomes less about working with Daniel's family per se and more about developing an embodied practice by which they can trace the history of a social fabric by discerning meaningful words. Sympathetic care, then, is not about anything positivist; it is an embodied awareness of the polyphonic attachment to affective tension, and the contemplative excavation, refraction, and realignment of divergent understandings.

ABSTRACT

German clinicians working with psychiatric crises employ an alternative therapy called Open Dialogue to excavate the family histories and interpersonal relationships of their clients. In learning to do this, they perform role-play exercises in which familial narratives are imagined and improvised. Through this process, they develop an embodied practice in which they attune to misalignments in the network through words. [care; dialogism; psychiatric crisis]

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