The Importance of Dialogue for Schizophrenia Treatment: Conceptual Bridges Between the Open Dialogue Approach and Enactive Cognitive Science

Laura Galbusera [† ‡]
8laura.galbusera@gmail.com

Miriam Kyselo [‡]
miriam.kyselo@gmail.com

ABSTRACT

In this paper we focus on the psychiatric approach of Open Dialogue (OD) and seek to explain why the intersubjective process of dialogue, one of OD's core clinical principles, is effective in schizophrenia treatment. We address this question from an interdisciplinary viewpoint, by linking the OD approach with a theoretical account of the self as endorsed by enactive cognitive science. The paper is structured as follows: first, we introduce the OD approach and focus in particular on the principles that are characteristic of the dialogical therapeutic attitude. Second, we clarify our stance on the concept of schizophrenia by relying on insights from phenomenological psychiatry. Third, we introduce an enactive perspective on mental disorders, which elaborates on phenomenological psychiatry and conceives of the self as a self-organizing system, brought forth through interactional processes. Based on this enactive approach, we draw clinical implications for schizophrenia. In the fourth and final part, we propose conceptual bridges between the OD and the enactive approach by bringing to attention the intersubjective nature of the human self and the inherent vulnerability entailed in both the self's maintenance and in the practice of dialogue. We then propose that the dialogical stance adopted by OD is effective in supporting the recovery of a balanced sense of self precisely because it provides an intersubjective space in which clients can safely experience and maintain the basic structures underlying the socially constituted self. Since our analysis touches upon fundamental structures of the therapeutic relationship, we hope that it will also be useful to inform general psychiatric practice and help advancing a more integrative understanding of psychotherapy for schizophrenia.

[†] Brandenburg Medical School, Department of Psychiatry and Psychotherapy, Immanuel Klinik Rüdersdorf, Rüdersdorf, Germany.
[‡] Technical University of Berlin, Berlin, Germany.

Schizophrenia is a psychiatric diagnosis that describes fundamental alterations of thought, perception and affect (World Health Organization, 1992). According to current diagnostic criteria, it is mainly defined by the presence of psychotic symptoms such as delusions or hallucinations (American Psychiatric Association, 2013). More recently, characteristic alterations of self-experience, affecting the most basic and minimal sense of self, have been also emphasized by phenomenological approaches in psychiatry as being central to this diagnosis (Sass & Parnas, 2003; Parnas & Sass, 2001).

1% of people in the world receive the diagnosis of schizophrenia. Yet, despite decades of research, the recovery rate is still low and many persons diagnosed with the condition continue to suffer over the long-term (Jaaskelainen et al., 2013; Zipursky, 2014; Clemmensen et al., 2012; Lang et al., 2013). The stigma attached to this diagnosis often also leads to situations of social exclusion, thus further hindering the recovery process (Kleim et al., 2008; Gerlinger et al., 2013).

Research on schizophrenia spans across heterogeneous fields such as psychology, social sciences, genetics, neuroscience, survivor research and mad studies, philosophy and psychiatry. There is a lack of collaboration and engagement across these fields (and their sometimes competing interests), which has often led to fragmentation and contradiction. This hinders an integrative understanding of the aetiology and treatment of the disorder (Bracken & Thomas, 2010). Another consequence of the fragmented research landscape is that it impedes progress in the improvement of clinical practice.

In this paper we seek to help overcoming fragmentation by bringing together research on schizophrenia treatment with conceptual insights from enactive philosophy of cognitive science. We focus in particular on a treatment approach called the Open Dialogue approach (OD), which has stood out in the last decades as an innovative and particularly effective treatment for psychiatric disorders and which has led to high rates of recovery from schizophrenia (e.g. Seikkula & Arnkil, 2006, 2014). We then look at the enactive approach to human selfhood, in particular at a relational variant (e.g. Di Paolo et al., 2010; Thompson, 2007; Kyselo, 2014) and we outline its implications for schizophrenia (Kyselo, 2016). Our goal is to engage OD and enactive cognition in a mutually enlightening dialogue, and to thereby contribute to a better and integrative understanding of schizophrenia and of what successful treatment of the condition could consist of. We argue that the enactive approach to the human self might help clarify why the intersubjective process of dialogue at the

heart of the OD approach might have a therapeutic effect in the case of schizophrenia.

The paper is structured as follows. In the first part, we briefly introduce the Open Dialogue approach. We thereby focus especially on what we take to be the characteristic principles underlying the dialogical therapeutic stance, i.e. openness and authenticity. In the second part, we clarify our stance on the concept of schizophrenia. To do this, we draw both on theoretical underpinnings of OD and on insights from phenomenological psychiatry. In the third part, we turn toward an enactive model of the self, which conceives of the self as an autonomous self-organized network, brought forth through social, interactional processes. We propose clinical implications, and describe how alterations of minimal self-experience typical of schizophrenia might be related to imbalances in the processes of relational self-organization that bring about the self. In the final and fourth part we bring the OD and the enactive approach together by first highlighting a common key notion: the principle of vulnerability. We conceive of it as, on the one hand, a pre-condition for the intersubjective process of dialogue and, on the other hand, as a basic human condition related to the intersubjective constitution of the self. We then conceptually bridge the specific intersubjective processes at the basis of dialogue and at the basis of self-constitution and thus argue more in detail *why* and *how* dialogue might be effective in restoring and supporting the minimal sense of self.

1. The Open Dialogue Approach

Open Dialogue (OD) is a psychiatric treatment approach developing since the 1980s in Finnish Western Lapland, a region which had a very high schizophrenia incidence (Seikkula et al., 2006). It stems from the Finnish National Schizophrenia Project, which was aimed at developing more effective psychiatric treatment for schizophrenia (Aaltonen et al., 2011).

The core principle of OD is *dialogue*. Following this principle, the first step in response to a psychotic crisis is always to engage in a dialogical relation with the client and her social networks and to make sense of the client's struggle in a joint effort. Treatment plans or strategies to deal with the crisis are thus not pre-given but co-constructed together with clients. Psychiatric treatment in OD consists first and foremost of psychotherapy (mostly in the form of dialogical network meetings) although pharmacological treatment may also be administered additionally, according to the case-specific needs. Delivering

psychiatric treatment through dialogical relations necessarily implies a form of open-endedness, which means that treatment is not predefined ad-hoc but might change in dependence of the specific persons and contingent situations. A constitutive part of the dialogical process is thus *tolerance of uncertainty* about its process and outcome (Seikkula & Arnkil, 2006, 2014).

A second fundamental principle of OD is to adopt a *social network perspective*. OD owes part of its origins to the tradition of systemic psychotherapy where the client's family and/or her social network are seen as playing a crucial role in the client's psychotic crisis. At the same time, it is considered as an important resource for helping to resolve it (Seikkula & Olson, 2003). OD treatment meetings thus include both healthcare professionals (e.g. nurses, social workers, psychologists, psychiatrists) and also members of the client's social network. During the treatment process all communication is kept transparent and decisions are always openly discussed and taken together with the clients and their networks.

OD thus basically consists in a dialogical process that involves multiple actors. But how is this process organizationally implemented in terms of psychiatric services? OD implies a radical reorganization of the entire healthcare system. The structural changes in OD were originally inspired by and developed within the Need-Adapted Approach, a person-centred model of psychiatric care (Alanen, 1997; Alanen et al., 1991). In line with this model, in OD the entire structure of the psychiatric services is shaped around the client's needs. Psychiatric services are decentralized, with increased home-treatment and less resorting to hospitalization. *Immediate intervention* plays a crucial role in such a decentralized organization of the psychiatric system: dedicated crisis units are responsible for organizing treatment meetings within 24 hours from the client's first contact with the hospital. The location and frequency of the treatment meetings is decided according to case-specific needs, which means that *flexibility and mobility* are core principles of OD's organizational structure. Importantly, OD guarantees a *continuity* of treatment in that the professionals involved in the first meeting, will take *responsibility* for the entire duration of the treatment process.

Research on the efficacy of the OD approach has shown very positive outcomes. About 80% of persons treated in the OD system were able to return to full-time employment or study. Only 33% of persons with schizophrenia spectrum disorders needed antipsychotic medication during their treatment with OD. Further support for the efficacy of OD is thatafter a few decades of its

implementation, a lower incidence of schizophrenia diagnosis in Finnish Western Lapland was observed (Aaltonen et al., 2011; Bergström et al., 2017; Seikkula et al., 2001b; Seikkula & Olson, 2003; Seikkula et al., 2006; Seikkula et al., 2011).

2. The Therapeutic Stance in OD: Openness and Authenticity

It is clear that there are many interconnecting factors at work in the OD approach. To clarify what exactly is the key of OD, in our previous work we have focused on the principle of dialogue (Galbusera & Kyselo, 2018). Proponents of OD conceive of dialogue as the crucial process through which therapeutic change is fostered. They describe it as the co-construction of a joint space in which experiences and emotions can be shared (Seikkula & Arnkil, 2014). To characterize this process of sharing, Seikkula (2008) uses the notion of *polyphony*, i.e. the inclusion of multiple voices. Importantly, in dialogue there are two kinds of polyphony: horizontal and vertical. *Horizontal polyphony* refers to dialogues *between persons*. It means that the perspectives of all persons present in the current conversation are included and heard. Vertical polyphony refers to the integration and inclusion of different voices *within a person's experience*. Thereby, the perspectives of persons who are currently not present are additionally brought to awareness through the narrations of the present persons. In this way, the dialogical processes can thus extend over space and time and allow a full-blown negotiation, exploration, contextualization and reframing of different voices at play (Seikkula, 2008).

Vertical polyphony, i.e. the dialogical integration of different voices (including the seemingly meaningless ones, pertaining to psychotic experience) within a client's narrative, has been identified as a central aspect of the recovery process in schizophrenia (Lysaker et al., 2001; Lysaker & Roe, 2012; Lysaker et al., 2005). But a coherent dialogue of different voices *within* the subject is fostered and constructed in the first place through engaging in dialogical relations *between* subjects (Lysaker et al., 2012; Seikkula, 2008). The OD meetings are thus a space in which vertical polyphony of a person's narrative and history is fostered and recovered through horizontal polyphony, i.e. through the sharing and negotiation of meaning in the here and now.

For initiating and maintaining this polyphonic dialogue, the attitude of the professionals toward the client plays a crucial role. Their primary aim and responsibility is indeed to create and sustain dialogical relations with the client

and their social networks (Seikkula, 2011). To do ensure this, all professionals working within the OD psychiatric service (psychiatrists, nurses, psychologists, social workers etc.) receive the same specific psychotherapy training and therefore develop a shared basic understanding and know-how of dialogical practice.

In order to better understand what a dialogical stance may consist of, in our previous work we have analysed its various descriptions and conceptualizations in the OD literature. We thereby carved out two necessary and sufficient components of a dialogical therapeutic attitude: *openness* and *authenticity* (Galbusera & Kyselo, 2018). First, we defined the principle of openness as an attitude in which the therapist recognizes, accepts and carefully listens to the client[1]. Being open also means that the therapist shows a certain readiness to be affected by the client and to adapt to her. The notion of openness encompasses further aspects such as attentive listening, acknowledging and accepting the other, respecting and taking her seriously, as well as adapting to the other person. These characterizations of the therapeutic stance have been repeatedly emphasized in the OD literature.

Second, the principle of authenticity is based on other characterizations of the therapeutic attitude in the OD literature, which have been less emphasized but are equally important. These include e.g. the therapist's active inquiry, transparent communication, personal resonance and her active participation as a whole person (both as professional and as fellow human being). We used the term authenticity, to summarize these aspects and define an attitude in which the therapist owns and actively expresses her own perspective in the interaction with the client (Galbusera & Kyselo 2018). However, a further specification of this notion is needed: expressing and acting upon one's own perspective, and affirming it in the interaction with clients, might indeed involve a dilemma for the professionals. The therapist can enter the interaction as a fellow human being, i.e. symmetrically, or she can do so as a professional, giving help and thus relating to the client in an asymmetric way. Often the tension between these two stances cannot be overcome without either falling into a symmetric human

[1] In OD, professionals work mostly with social networks and not with single clients. Yet, for reasons of language simplification in this paper we will describe the dialogical stance mainly referring to the dyadic relation between therapist and client. We believe that the basic structural features of the dialogical stance apply in the same way to both dyadic and more complex multi-actor settings. We acknowledge that multi-actor settings entail an additional complexity and different interactive dynamics, yet there are out of the scope of the present investigation.

relation and thereby running the risk to undermine the therapist's professional responsibility, or by imposing an asymmetric and professional relation, thereby risking to deny or downplay the client's autonomy. We believe that authenticity offers a way out of this dilemma: if professional responsibility was seen as part of the therapist's subjective stance, then authenticity would allow for the integration of professionalism into a human relation. Thus, the therapist's authentic stance involves both, personally caring for the client while also taking a particular professional responsibility towards her. Professional knowledge, decisions, responsibility are not imposed as a-priori truths, but are presented as a part of the therapist's own authentic viewpoint. In this way, the therapist can introduce the professional dimension into the therapeutic relation without denying the client's autonomy. The notion of authenticity thus allows accounting for both the therapist's personal as well as her professional stance, which are both important aspects of the dialogical therapeutic attitude in OD (Galbusera & Kyselo, 2018).

Openness and authenticity are complementary aspects of a dialogical stance. Together they enable a twofold movement of stepping back and stepping forward into the interaction: first by offering space for the other person to join the interaction (openness) and secondly, by joining the other person in the interaction (authenticity). Both attitudes are necessary and counterbalance each other, in a kind of "dialogical dance". A therapeutic stance, which is only based on openness, risks falling into a mere witnessing attitude, where the therapist listens and adapts to the client without herself actively contributing to the interaction. In contrast, a therapeutic stance, which is only based on authenticity, might result in a merely "instructive" stance, in which the viewpoint of the therapist dominates that of the client. If taken to the extreme, in both scenarios the relation between therapist and client would run the risk of taking the form of a mere monologue by either one of them. If the therapeutic stance would only be characterized by openness, then the monologue would be by the client, whom the therapist listens to. In the other case, that is, if only authenticity would be emphasised, the therapist's viewpoint would dominate the interaction leading to a monologue on her side. A dialogue thus requires the inclusion of (at least) two subjects, as Buber (1987) has also emphasised. An attitude that comprises openness and authenticity by the therapist would allow the establishment of such an inclusive, inter-subjective space in which dialogue can happen (Galbusera & Kyselo, 2018).

Importantly, the dialogical space created through a stance of openness and authenticity requires vulnerability. Opening up to others and showing oneself authentically implies taking the risk of being affected by others in unpredictable ways. Being vulnerable in dialogue thus means letting oneself being affected, letting go of control over the interaction and giving in to it. It is tightly related to the notion of uncertainty (and the need to tolerate it) described a core and feature of the dialogical process (Seikkula & Arnkil, 2006, 2014). By being open and authentic the therapist thus adopts a vulnerable stance and, in joining the dialogical process, clients are invited to do the same. Openness and authenticity are a way of acknowledging and allowing vulnerability in the client's experience. Yet importantly, in the twofold dialogical movement of openness and authenticity, vulnerability can be experienced *safely.* To experience the openness of the therapist might help reducing the common fear of rejection and isolation (fear of loosing the other). Experiencing the authentic contact with her might in turn help reducing a common fear of merging and loosing interpersonal boundaries (fear of loosing oneself). A balanced stance of openness and authenticity avoids falling into either forms of monologue. The contextual framework of OD, given by the principles of *continuity* of treatment, *flexibility and mobility* and r*esponsibility*, also contributes to the feeling of safety needed to sustain vulnerability. In this way, the usually negatively connoted notion of vulnerability might be thus positively reframed as a core aspect of the dialogical process. In particular, by bringing together OD and enactive cognitive science in this paper we will suggest that the experience of *safe vulnerability* might be what in principle allows therapeutic change (see pp. 20-25).

The therapeutic stance described in OD shares important similarities with other dialogical, systemic, phenomenological, psychodynamic or client-centred approaches to psychotherapy (e.g. Rogers, 1951; Lysaker et al., 2012; Stanghellini & Lysaker 2007; Thoma, 2019; Benedetti, 1983). For that reason, the fundamental characteristics of the dialogical therapeutic attitude, which are the focus of the current analysis, might thus be considered as being clinically relevant across and beyond specific psychotherapy orientations. To shed light on the workings of the dialogical therapeutic stance might therefore not only lead to a better understanding of the therapeutic process in OD but also to a more integrative understanding of psychotherapy for schizophrenia in general.

So far we have proposed a clarification of what exactly the dialogical stance in OD might consists of. As a reminder, we have conceptualized it as a combined stance of openness and authenticity (Galbusera & Kyselo, 2018). However,

what remains unclear is *why* this two-fold intersubjective stance might have a therapeutic effect in the specific case of schizophrenia. In this paper we provide a possible answer to this question by proposing a tentative explanation for the efficacy of dialogical processes in schizophrenia treatment. We achieve this by linking the clinical OD approach with an enactive conceptual proposal for the human self and schizophrenia.

In order to bring together approaches from different disciplines, a terminological clarification is first needed. By making explicit our choice of terms, we aim at building a bridge that allows linking the Open Dialogue approach, in which general terms such as "psychosis" or "personal crises" are used, and approaches in phenomenology and cognitive science, where the term schizophrenia is used to specifically describe "disorders of the self". In the next section we thus make a short digression to clarify what we mean by the term schizophrenia. Our aim is hereby not to find solutions to the scientific debate on the notion of schizophrenia but only to provisionally help clarifying this term. This might allow, for the limited scope of this paper, a coherent and joint discussion of the two approaches.

3. Clarifying the Concept of Schizophrenia

Proponents of the OD approach usually refer to a social constructionist perspective on mental disorders (Seikkula et al., 2001a, 2001b). According to this, terms such as schizophrenia or other diagnoses are viewed as only *one* possible description among many others for defining and naming given psychological struggles or symptoms. Such notions or 'labels' construct the reality in particular ways, which can be judged as more or less valid and useful (Gergen, 2009). Social constructionist accounts have criticized epistemological shortcomings behind the dominant discourse of mainstream biological psychiatry, thereby showing in particular the lack of validity behind the current DSM notion of schizophrenia (Bentall, 2003; Read & Dillon, 2013; Boyle, 2002). The diagnosis of schizophrenia has been also criticized as being an unreliable construct, which additionally bears the negative connotation of a chronic brain disease (Van Os, 2016). The term schizophrenia has been thus rejected in favour of broader and less stigmatizing categories such as "psychosis", which include a more heterogeneous spectrum of symptoms and behaviours (e.g. Bentall, 2013).

To rely on a social constructionist view of mental disorders thus means to challenge and to go beyond the label of schizophrenia as defined by current diagnostic classification systems such as the DSM (American Psychiatric Association, 2013) and to consider instead the meaningfulness of symptoms in their specific context. This approach is in line with the dialogical view in that it rejects the objectification of patients as 'broken brains' and instead views them as fellow human subjects who are struggling to make sense of their own difficult experiences. In this way, the social constructionist perspective supports the creation of more dialogical subject-subject relations (in the sense of Buber) in mental health settings.

We agree with proponents of a social constructionist critique to the extent that the current psychiatric diagnostic definition of schizophrenia lacks validity and reliability and thus similarly reject a reductionist view of schizophrenia as a brain disorder. Nevertheless, we also see merit in the phenomenological approach to psychiatry, which endorses similar critique of current diagnostic classification criteria yet also proposes alternative definitions of schizophrenia (Parnas et al., 2013). This alternative is based on descriptions of typical alterations of experience, which allow for differentiations within the broader spectrum of psychoses.

Based on a shift in the epistemology and ontology of the psychiatric object, phenomenological psychiatry has focussed on qualitative transformations in the structure of experience conceived as an integrated meaningful whole instead of looking at single symptoms and behaviours as disconnected entities (Henriksen & Parnas, 2012; Parnas et al., 2013). It described the kernel of the schizophrenic experience as an alteration of the sense of self and of intersubjectivity (Sass, 2001; Sass & Parnas, 2003; Pienkos, 2015; van Duppen, 2017). This phenomenological approach particularly proposes that in schizophrenia the person struggles with the weakening of her pre-reflective sense of being a first-person subject of experience as well as with the weakening of self-boundaries and self-coherence at the most basic and pre-reflective level (Parnas & Sass, 2001; Sass & Parnas, 2003). From a first-person perspective, schizophrenia implies the experience of losing the centre from which experience originates and gets organized (Saks, 2007; Kean, 2009). These changes target the most primary and embodied level of selfhood (ipseity) and are tightly related to changes in the pre-reflective relation to the material and social environment (Henriksen & Parnas, 2012; Cermolacce et al., 2007; Sass, 2001; Stanghellini & Ballerini, 2004). Several empirical studies have shown that these

characteristic phenomenological features, and their operationalization by Parnas and colleagues (2005), constitute a more reliable description of schizophrenia than the DSM definition (Møller et al., 2011; Nordaard et al., 2012; Parnas & Henriksen 2014; Haug et al., 2012).

Although the term schizophrenia is generally avoided in research on Open Dialogue, we decided to use it in this paper, and thereby follow the phenomenological approach to psychiatry. The reason for this is that we are interested in something more specific than the broader and heterogonous category of "psychoses". We believe that the therapeutic effect of dialogue is particularly relevant and should be better understood especially in relation to the alterations of minimal self-experience as proposed in phenomenological definitions of schizophrenia.

Nevertheless, there is another important aspect, in which we elaborate on (and depart from) the phenomenological approach. We agree that the phenomenological conceptualization of schizophrenia might contribute to a better *understanding*[2] of the disorder, yet we thereby do not comply to *explanatory* claims often related to it. Indeed, these have often led to an unjustified equation of the experiential alteration of self-experience with an ontological abnormality of the self (e.g. Sass & Parnas, 2007; Sass, 2010). In this paper we instead embrace the idea that schizophrenia can be first and foremost *phenomenologically* described as a disturbance of the experiential sense of self (or ipseity) as well as of intersubjectivity. But, in order to make sense of schizophrenia from an *explanatory* perspective, we will have to move beyond phenomenological considerations and look toward an existential and social ontology of the self as proposed by enactive cognitive science. The background assumption for this is that any account or reflection on a disorder of the self and intersubjectivity must be grounded, first, in a theoretical framework about the ontological nature of the human self and human intersubjectivity more generally and second, be preceded by a clarification of how self and intersubjectivity are actually related. In the next section we thus introduce an

[2] We here refer to *understanding* and *explanation* as two different epistemic modes (Jaspers, 1997). Whereas the first is confined to the phenomenological level of experience, i.e. describing and understanding the unfolding of one experience into the next and the meaningful unities in which experiences can be contextualized, the latter involves the establishment of causal relations, i.e. going beyond the experiential realm into the ontological realm of causality. In Husserl's terms, one might reformulate Jasper's distinction as the one between the physical causes (of explanation) and the motivational reasons (of consciousness).

enactive approach to the self, which proposes to integrate both an experiential and ontological account of selfhood and will thus allow us to derive important implications for schizophrenia. Following this, we then conjoin this enactive clarification with the Open Dialogue perspective, putting forth the idea that schizophrenia can be conceived as a particular form of dialogical struggle.

4. The Enactive Approach to the Self

In this section we introduce the enactive approach to selfhood, focussing particularly on a recent variant, according to which self is social and relational at its core. The enactive approach to selfhood has its roots in the seminal work on enactivism and embodied cognition by Varela and colleagues (Varela et al., 2017), bio-philosophical accounts of the organismic identity (Thompson, 2005, Buhrmann and Di Paolo, 2017), as well as the phenomenological tradition, particularly as endorsed in the works of Merleau-Ponty (e.g. 1962/2002). What is common to these approaches is that they challenge Western or "naïve" conceptions of the self as a single, egocentric entity, which remains constant through time and exists quite independently of an outside, objectively given world. The enactive approach endorses a view of groundlessness instead, whereby individual and world do not appear as ontologically distinct but instead as inextricably interwoven and co-constructed (Varela et al., 2017). Following this, the self is considered as a processual entity that emerges on the basis of continuous engagements with the environment, both structurally and experientially (Thompson, 2005, 2010). What allows proponents of the enactive approach to still speak of the self as a form of unifying principle and as something that separates one subject from another is their emphasis on embodiment and the concept of autonomy. Minds are not reducible to the brain but instead "embodied in our entire organism and embedded in the world" (Thompson, 2005, p. 408). The self then is a bodily or embodied self and requires to be actively engaged with the world. For a coherent self, our bodily engagements with the world have to be organized into an integrated whole. This is where the notion of autonomy comes into play. It refers to the insight from biophilosophers Maturana and Varela (1980) that the boundaries of the organism are not given but continuously generated through so-called *operational closure*, a process in which the organism actively excludes some of the material and interactive engagements with the environment from the basic operations by which it maintains its metabolic integrity. This process of self-

maintenance is called *autonomous* or self-organized because in order to achieve it the organism relies on its own self-generated activity and is not determined by the external environment (Thompson, 2005; Di Paolo et al., 2010). While first wave views of the enactive self emphasise the importance of sensorimotor engagements in the make-up of the self's organisation (Di Paolo et al., 2017), in this article we will focus on a recent elaboration on the enactive self by Kyselo (2014) that puts stronger emphasis on the importance of intersubjective engagements. Indeed, Kyselo (2014) proposes to specify the processes essential to the self's organisational structure in terms of social processes of *intersubjective* behaviour and action, rather than *individual* bodily activity. The bodily self is therefore at once a social self, for in being intentionally directed at the world qua our embodied existence we are also at once attuned to and constantly affected by each other (Heidegger, 1927/2001; Merleau-Ponty, 1962/2002). What distinguishes one self from another is thus not merely the fact that we inhabit different bodies, but also that we integrate different loops of social engagements and relations with others. Crucially, this cannot be achieved on our own but only through engaging with others throughout our lives. Kyselo (2014) thus proposed an account of the self as an autonomous network of *socially constituted* processes, which for its maintenance and integration actively relies on being engaged with or related to others. In this way, the self is neither an egocentric entity nor merely embodied. It integrates a sense of differentiation from others with a sense of connectivity with them. This is reflected in the special way in which the social interactions and relations making up the self as autonomous network are organised, namely in terms of so-called *social needful freedom* (Kyselo, 2014).

Social needful freedom elaborates on philosopher of biology Hans Jonas' (1966/2001) concept of *needful freedom*, which refers to the individuation of an organism in terms of material or organic relations. According to this, these relations take two different forms, a *dependence* on material processes and at the same time a striving for *emancipation* from them. *Social* needful freedom extends Jonas' concept of needful freedom to the level of sociality and the human self. Here, the tension between needfulness and freedom arises as a need to balance an independence from and dependence on social interactions and other human beings. This is achieved through continuously balancing acts of emancipation from other subjects, on the one hand, and acts of being open and connected to them, on the other hand. Without acts of emancipation (freedom) the human self would risk merging with the other(s). Yet, acts of connection and

openness towards others are also required in order to avoid isolation. They ensure that the individual can become and maintain a self through the "contribution" of others, by being ready to be affected or perturbed by social interaction and relations (needfulness). This double structure of the self is specified in terms of social processes of *distinction* and *participation*. *Distinction* can either refer to the individual's emancipation from certain social relations and interactions, or, within a particular interaction, from being affected or perturbed by the other, by for instance pursuing more individually and less interaction driven goals. *Participation*, in turn, can either refer to the opening towards and relying on specific interactions and relationships or, within a particular interaction or relationship, the readiness for being perturbed or affected by the other, thus being more prone to adapt to the interactive and joint rather than individual goals. Even though distinction and participation can to some degree outweigh each other (a person might be generally more or less prone to be open and ready to be affected by others), both of these movements are necessary in general for there to be a self. They are therefore precariously linked and enable each other: a striving for distinction ensures that participatory tendencies do not lead to a loss of self and a striving for participation ensures that a person does not end up in social isolation (Kyselo, 2014). Following the enactive view of the complementarity of first- and third-person perspectives, the self is social not only in an ontological sense. According to the enactive approach, autonomous systems are goal-driven: they seek to maintain their identity thus to evaluate interactions with the environment so that they serve the goal of preserving their own self-organization (Weber & Varela, 2002). This constitutes a very basic, subjective outlook on the world, i.e. a first-personal viewpoint of care and concern. The two-fold social ontological structure of the enactive self is thus mirrored at the level of first-personal experience: *distinction* refers to a pre-reflective sense of self in terms of agency, independency, ownership, mine-ness or of being in control (Zahavi, 2014) , while *participation* refers to a sense of self in terms of openness, connectivity, a joint "we-state" or of being ready to be affected and supported by others (Kyselo, 2014).

With respect to the present paper we would like to highlight three important implications of the social variant of the enactive self. The first one emphasises that in order to maintain relational autonomy, humans need to permanently strive to balance two opposite needs: being distinct from and participating with others. Because these needs are opposed, there is a continuous tension at the heart of being a self, which constitutes a basic two-fold

existential norm that can never be fully overcome so as long as a person is alive. In order to maintain our self we need to allow for change and growth. The self is never fixed or independent from the environment, but rather an open-ended process, continuously in the making, and the result of constant maturing. Crucially, this process expands beyond childhood and early development throughout the duration of our entire lives.

The second characteristic of the enactive self is that it is not only subject to change from a temporal perspective, but also with regards to the very organizational structures that enable the active negotiation between the two-fold needs of connection and emancipation. The mechanisms underlying these structures do not reside within the individual alone (say within her brain or the organismic body itself) but instead transcend organismic boundaries to comprise relational engagements with other subjects. No one can be a self on their own. It is only through relating to others that the individual is able to achieve the necessary two-fold norm of being both connected to and separated from others. Being a self requires sociality – even when it comes to our sense of differentiation from others.

The third important characteristic follows directly from the previous two: because of its processual and open-ended nature, the self is a genuinely fragile and a constitutively vulnerable entity (Kyselo, 2015a). This is the case in two senses. The self is firstly vulnerable because the process by which its boundaries are constructed involves a basically paradoxical principle. Since humans seek to preserve both a sense of separation and of connection and these senses are opposed, they need to balance them. This entails a potential risk of imbalance and requires a trade-off, i.e. in observing either one of them one must ensure not to violate the respective other. The second sense in which the self is vulnerable has to do with its proposed social ontological status as a process that necessarily comprises the engagement with and contribution of other subjects. If being a self is something that requires the contribution of others, then we are always only relatively in control of who we are. This makes us genuinely vulnerable. Firstly, others can constitute a permanent source of potential perturbation to our own possibilities of connecting with or of feeling independent from others. They might thus potentially impede or pose perceived threats to our own goal's of self-maintenance and/or violate our own relational needs or expectations. Importantly however, vulnerability should not be read exclusively in a negative sense. The fact that we need others to maintain a healthy sense of self, secondly, means that engaging with others is also our most important resource for

maintaining a balanced sense of self and for helping us to regain it, once it is threatened or lost.

5. Implications for Schizophrenia

The enactive model of the self has important implications for our understanding of mental disorders and thus also for how we might conceive of schizophrenia, more specifically. Approaching mental disorders from an enactive perspective means to first of all embrace the general tenets of the autonomy-based view (Di Paolo et al., 2010; Thompson, 2007; Kyselo, 2014) and the associated ongoing process of boundary construction in terms of relational self-organization. The enactive approach thereby adopts a dynamical perspective on disorders suggesting that, just like identity in general, they emerge through an interplay of individual and as well as of environmental and interaction processes (Fuchs, 2009; Colombetti, 2013; Kyselo, 2014). When it comes to understanding a disorder, the enactive approach to the self would therefore look at the individual self as a social whole emerged and emerging through relations and interactions with others. If being a self necessarily involves a continuous structuring of a person's social existence together with others, then a disorder of the self must be primarily seen as a problem or disturbance within the dynamical interplay between individual and worldly processes that this involves.

This view is generally coherent with the biopsychosocial approach in psychiatry (Engel,1977). More specifically it is also in accordance with constructivist and social constructionist clinical proposals. Guidano's (1991) post-rationalist constructivist approach for instance suggests an understanding of mental disorders in terms of a processual view of the self, conceiving of it as an autonomous self-organizing system. More recent social constructionist models of mental disorders have emphasized not only the autonomy (organizational closure) of human identity but also the fact that the human self is constitutively open and it is thus co-constructed through social interactions (e.g. Neimeyer & Raskin, 2000; Ugazio 2013; Procter, 2015). These clinical approaches seem to share the same theoretical roots (e.g. Maturana & Varela, 1980) as enactive cognitive science, yet these two discourses have remained so far separate from each other. Although it is out the scope of this paper, we believe that the recent developments in enactive cognitive science (presented above) might usefully inform such clinical approaches and thus our understanding of mental disorders.

The enactive approach applies this dynamical view on mental disorders to the specific case of schizophrenia (Kyselo, 2016). It draws on the notion of schizophrenia from phenomenological psychiatry, thus considering the alteration of the minimal sense of self as a distinct phenomenological feature of the diagnosis (Sass & Parnas, 2003; Parnas & Sass, 2001). Yet it also emphasizes that the minimal self cannot be conceived separately from its engagement with the world and with others. Alterations of minimal self-experience should thus be necessarily understood as alterations of the self-in-the-world and especially of the self-with-and-through-others (Kyselo 2016, Krueger 2018). A recently formulated enactive hypothesis on schizophrenia thus suggests that disorders of minimal self-experience must be accounted for in terms of intersubjective processes (Kyselo, 2016).

The enactive hypothesis on schizophrenia starts from the assumption that alterations in the minimal sense of self do not presuppose an *ontological* abnormality of the individual subject. Instead, the person experiencing schizophrenia is approached first and foremost as a full human *social subject*, whose ontological condition, like that of every other human being, presupposes an ongoing care about the preservation of the self and the integration of two basic relational motives and action tendencies (called distinction and participation). These processes of relational self-organization imply an existential struggle that is necessarily common to all human beings and which is what makes the self a genuinely vulnerable phenomenon. The enactive hypothesis then proposes that in schizophrenia the struggle is not different in principle but it is exacerbated: the client experiences an imbalance or difficulty to integrate the two basic relational processes of distinction and participation. Rather than signifying the absence of normalcy, schizophrenia must be thus viewed as an extreme experiential condition that is situated on a continuum of human social and relational existence. Since the negotiation of the primordial tension between being connected and distinct sits at the very core of self-constitution and self-maintenance, problems to balance the tension could have severe consequences such as the alteration of minimal self-experience (Kyselo, 2015b, 2016). To emphasize, problems in the relational processes of self-organization should not be thought of as an innate deficit of the person, due to e.g. merely genetic predispositions. They should be rather conceived systemically, as possibly arising in the interplay between the person (with her own narrative, biological and genetic predispositions) and her social environment.

Considering schizophrenia from this perspective means to bring to attention the paradox that the negotiation between these opposed needs necessarily involves and the particular struggle that clients may have in negotiating it. Indeed, the proposal is that in schizophrenia the quite natural tension between the processes of distinction and participation becomes particularly prominent. The person might thus experience a pronounced difficulty to negotiate the paradox and even experience the two poles of distinction and participation as mutually exclusive. While the person might still try to re-establish a balance between them, the struggle in achieving this becomes so extreme or strenuous that her attempts to secure self-maintenance lead to a deepening of the tension instead of to its balancing. This might lead to a breakdown of the individual's (experienced) boundaries and to the severe symptoms that we know accompany this loss of self and others (Kyselo, 2016).

A useful illustration of the existential struggle presumed in the constitution of the self is for instance offered in Kean's (2009) first-person account of schizophrenia:

> For example, if a person relates too much to the outside world, to such an extent that he ignores his own internal self, this may result in him feeling being engulfed by others. On the other hand, if one finds little or no connection to the world, he may think that his self is going to implode and destroy him from the inside. Basically, I call this relationship existential permeability. (p.1035)

From the subjective viewpoint of the person who suffers from schizophrenia, a perceived imbalance in the intersubjective oscillation might thus be experienced as a sense of isolation, which could be explained by a more extreme degree of distinction. In contrast, when the degree of participation is too high relative to that of distinction, the client might experience this as a loss of self and have feelings of immersion in the world. Extreme instances of distinction and participation are recognized in typical phenomenological manifestations of altered self-experience (see Parnas et al., 2005). This includes on the one hand experiences such as threatening bodily contact, loss of self-other distinction, self-reference phenomena, passivity mood, all of which imply a loss of boundaries and a sense of merging with the other (instances of extreme participation). Further phenomenological manifestations might include experiences such as diminished presence, loss of common sense, social withdrawal or catatonia, which represent a feeling of disconnection from the external world (instances of extreme distinction).

In summary, the enactive hypothesis suggests that an exacerbation of the existential struggle in maintaining the intersubjective constitution of the self might underlie the alteration of minimal self-experience typical of schizophrenia (Kyselo 2016). Accordingly, schizophrenia might be re-formulated in terms of a dialogical struggle: the client oscillates between extreme participation (to the experience of merging with the other) and extreme distinction (to the withdrawal into a delusional reality) without achieving the experience of integration of the two poles. The *dialogical struggle* in schizophrenia thus consists in the experienced difficulty of dialogically integrating distinction and participation, self and other.

The enactive hypothesis is coherent with dialogical theories of schizophrenia (e.g. Lysaker et al., 2001, Lysaker & Hermans 2007, Lysaker & Lysaker 2011), which have been also used to explain the therapeutic process of OD (e.g. Avdi et al., 2015). But there are also important differences. Dialogical theories understand the "collapse of the dialogical self" (Lysaker et al., 2001) as a struggle to integrate different narratives in an internal dialogue. Dialogical theories of schizophrenia have thus mainly focussed on the vertical polyphony of personal narratives within the self. The enactive approach, in contrast, acknowledges the importance of internal dialogues but also situates the dialogical struggle at a deeper level, namely at the heart of the very constitution of the self, and thus at the most basic and pre-reflective level of selfhood. What is at stake is therefore also the possibility of achieving horizontal polyphony, i.e dialogue with others in the here and now of actual social interactions[3].

We believe that these clinical implications from enactive cognitive science might contribute to a dialogical understating of schizophrenia and constitute a useful theoretical tool for better understanding the therapeutic principle of dialogue. In the next section we thus propose conceptual bridges between the OD and the enactive approach with the aim of explaining why dialogue is of crucial importance in the treatment of schizophrenia.

6. The Importance of Dialogue in Schizophrenia Treatment

The enactive and the OD approach both emphasize the centrality of the intersubjective dimension: as the locus of a struggle for the maintenance of a

[3] The horizontal and pre-reflective (and pre-narrative) dimension of dialogue in the understanding of schizophrenia and its treatment has been the focus of Stanghellini (2016) more recent work, which is coherent with the enactive proposal of this paper.

distinct yet open self and as the core of the recovery process in schizophrenia which takes place through dialogue. In what follows, we focus on and explore this intersubjective dimension and suggest that conceiving schizophrenia as an intersubjective (dialogical) existential struggle might help explain why dialogical treatment is so effective. To unpack this proposal, we first highlight a further general aspect common to the two approaches, namely the central importance of human vulnerability[4]. Based on this, we analyse in a second step the specific intersubjective dynamics of OD and of the enactive self in order to explain in more detail how exactly might dialogue foster and support the recovery of a balanced sense of self.

Both OD and the enactive approach emphasize the centrality of *human vulnerability*. On the one hand, the enactive approach suggests that human existence as such is intrinsically vulnerable, and that this becomes most evident in schizophrenia. Here, vulnerability is primarily conceived of as grounded in the intersubjective and inherently paradoxical principle of relational self-organization. A person struggling with schizophrenia continuously runs the risk of falling either into a complete immersion with the other, thereby (temporarily) losing the sense of being someone in their own right, or of falling into complete isolation and disconnection from others, thus (temporarily) losing the possibility of intersubjective contact and support, necessary for her to be a self. The OD approach, on the other hand, has shown that a certain degree of vulnerability is also present in dialogue. Dialogue is a co-constructed endeavour, which rules out the possibility of either one of the participants fully steering or controlling the outcome of this intersubjective process. It is therefore inherently uncertain. Engaging in dialogue requires taking a risk by opening up and by authentically showing oneself to others, all while not always knowing what will happen next. Dialogue does not deny vulnerability, but instead embraces it as vital to its own precondition.

From an enactive perspective, we propose that dialogue might be viewed as the space in which the person can experience and learn to deal with an existential vulnerability that is intrinsically human, but that becomes extreme in the case of schizophrenia. The core argument is that if the self was indeed socially constituted, then by supporting the clients in dealing with the

[4] Here the term vulnerability should not be understood as negatively connoted. It refers to the radical openness of the human self and to the fact that the human self deeply depends on interaction with others. This can have both positive and negative consequences depending on the quality and types of relations we rely on.

vulnerability inherent to intersubjective self-organization underlying this (i.e. balancing both the sense of distinction and participation without being pulled into its extremes) we might at the same time support them in the recovery of a balanced sense of self. In other words, the effectiveness of dialogue might consist precisely in the possibility of experiencing a *safe vulnerability* in the dialogical process without loosing oneself (through merging with the other) and without loosing the other (by isolating oneself). What reduces the risk of falling into the extremes of loosing oneself or the other is the fact that a dialogical process necessarily includes (at least) two subjectivities. For dialogue to be maintained, the participating persons' subjectivities must be maintained too. By highlighting the importance of vulnerability of the human self, the enactive approach also helps to shed light on why aspects such as safety and trust are so important in the treatment of schizophrenia. The OD principles of responsibility and continuity of treatment may indeed be seen as serving a kind of "existential baseline function", as they ensure the possibility of continuous engagement in the dialogues in a context of trust and safety.

The proposal *that* dialogical relations might play a crucial role in supporting a person's sense of self is also coherent with other dialogical approaches, which have emphasized that dialogue might support the recovery of a sense of self (e.g. Lysaker et al., 2012; Stanghellini and Lysaker, 2007; Stanghellini, 2016). Yet what these accounts do not explain is what exactly happens in dialogue. To put the question more specifically, *how* exactly can a dialogical therapeutic stance support the strengthening and recovery of a balanced sense of self? To answer this question, we explore in the following the linkage between the intersubjective processes of dialogue and of human self-constitution in more detail. We thereby provide a tentative explanation for the mechanisms underlying the effectiveness of dialogue in schizophrenia treatment.

According to the enactive theory of the self, humans, qua being social beings, must relate to each other and contribute to each other's self-organization and maintenance. Our hypothesis is that a dialogical attitude, conceived as a stance of openness and authenticity, might provide the basis for a particular type of relation that supports individuals in balancing the processes of participation and differentiation. We suggest that the two constitutive parts of the dialogical stance, i.e. openness and authenticity, mirror and therefore also foster the intersubjective processes of distinction and participation. Let us explain this in more detail.

Recall that the attitude of openness implies acknowledging, recognizing, listening and adapting to the other person. We suggest that because of this, openness mainly fosters the dimension of participation. Indeed, acknowledging and accepting the other without preconceptions or prejudices has the effect of keeping the other person engaged in the interaction and induces a readiness to being affected by the dialogue. Adopting a stance of openness helps expanding the other person's potential space for participation. This can be achieved by for instance addressing and taking seriously any manifestation and expression coming from the other person. But at the same time, openness may also support a sense of distinction. Openly acknowledging otherness and idiosyncratic behaviour means addressing and validating the other person as a distinct being, namely as a person in her own right. Being taken seriously, and thus retaining the right to be and bring whoever she is into the social interaction, may strengthen the sense of distinction of the person. Being listened to also gives legitimacy to one's own meaning-making and subjective experience.

The counterpart of openness is authenticity, i.e. an attitude by which one brings and expresses in the interaction that, who one is. We suggest that responding authentically may afford a sense of distinction in the other. Dialogue does not only require to listen to and to acknowledge the other, thus potentially leaving the whole interactional space for her. Rather, by expressing her own authentic experience and thoughts, the therapist "breaks" or challenges the other person's expression and takes up her own part of the interactional space (Galbusera & Kyselo2017). By answering authentically as a distinct person, the therapist helps creating a constraint, and potentially an intersubjective boundary through which the client can make the experience of being distinct as well even if they might struggle to do so otherwise. Additionally, being authentic also means showing one's emotions and sincerely expressing one's own thoughts, thus taking a risk and accepting the vulnerability that comes with it. In doing so, the therapist invites the client to do the same. Indeed, letting oneself be engaged in the first place might motivate the other to engage in the interaction as well. In this way, authenticity might also be seen as fostering participation.

Both openness and authenticity are required to foster and sustain the intersubjective processes of distinction and participation and to avoid falling in either of these two poles. For example, a stance only based on openness would foster more participation, but if it is not counterbalanced with authenticity, and thus distinction, it would run the risk of loosing intersubjective boundaries.

Similarly, by responding authentically the therapist would help create interactional constraints that support a sense of distinction. Yet when this is not balanced with a sense of openness toward the client's own expression, and thus with participation, it would risk disengagement on her part. Re-balancing of the experiences of distinction and participation thus requires openness and authenticity to be co-present in the therapist's stance.

By providing a locus of differentiation and engagement, dialogue might enable the co-presence and balancing between the two existential poles of distinction and participation. Through the dialogical attitude of the therapist, the client is thus offered the possibility to experience and perceive herself as a distinct and at the same time as a participating subject. In this way, she can experience both intersubjective connection and boundaries even if she might struggle to do so outside the therapeutic context. The dialogical attitude of openness and authenticity can thus be thought of as the intersubjective matrix through which the processes crucial for self-maintenance are shaped and fostered. This can be depicted in a chiastic structure in which openness and participation on the one hand, and authenticity and distinction on the other hand mutually complement each other (Fig. 1). This chiastic structure shows elements of both openness and closure that the enactive and the OD approach have shown to be at the basis of respectively human self-constitution and dialogue. Because the two-fold structure of the dialogical stance mirrors and fosters the two-fold intersubjective process of self-constitution, we suggest that dialogue is of central importance in schizophrenia treatment as it is the key for supporting the client's recovery of a balanced sense of self.

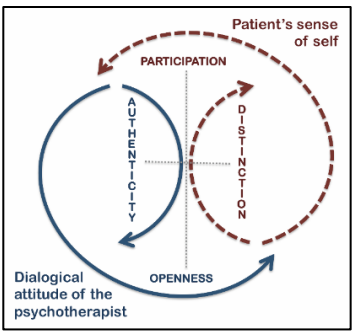

Fig. 1. The chiastic structure of the dialogical stance and the intersubjective processes of self-constitution. The dialogical attitude of openness and authenticity mirrors and fosters the twofold intersubjective movement of distinction and participation, which is at the basis of the generation of the sense of self.

7. Conclusion

In this paper we aimed to provide a possible explanation for why dialogue is effective in the treatment of schizophrenia. In order to address this question, we have adopted an interdisciplinary outlook and presented conceptual bridges that helped bringing together insights from the clinical OD approach and the enactive approach to cognition and selfhood.

We have first emphasized the centrality of an existential vulnerability entailed in the intersubjective nature of the process of the constitution of the human self. In the case of schizophrenia clients struggle particularly with this social process of the self's constitution.We have thus stressed the therapeutic function of dialogical relations as enabling the vital space in which the person can experience and learn to deal with this basic human intersubjective vulnerability and where she can alleviate the struggle without neither loosing nor isolating herself. To clarify this proposal, we have explored in more detail the linkage between the specific intersubjective processes of enactive self-constitution and the dialogical process.

The enactive approach conceptualizes human selfhood as a self-organized system, which is maintained through interactional processes bringing about a balanced sense of distinction and of participation. We hypothesized that an imbalance in these interactional processes might be the key for understanding the alterations of minimal self-experience in schizophrenia. We then proposed that the two-fold dialogical stance of the therapist, consisting of openness and authenticity, would allow recovering the balance between them. Rather than providing final answers, our proposal might serve as a tentative explanation for why and how dialogue is effective in the treatment of schizophrenia and as invitation for further dialogue and for research, both conceptually and empirically.

We hope that the theoretical insights outlined in this paper might also usefully inform the theory and practice of other psychotherapy approaches to schizophrenia. Indeed, a dialogical therapeutic stance based on openness and authenticity might be viewed as a helpful factor, common to several psychotherapy and psychiatric approaches. We do not wish to claim that the dialogical stance should be considered as the only therapeutic factor for schizophrenia therapy; there are indeed other crucial factors which have been extensively investigated and for instance touch upon processes of bodily (e.g. Galbusera et al., 2019) emotional (e.g. Ciompi, 1997) and narrative (e.g.

Lysaker et al., 2001) integration. However, we believe that dialogue might constitute a necessary structural basis, a background condition, for initiating and sustaining other therapeutic processes aimed at supporting and reframing the self at the bodily, emotional and narrative levels.

We are convinced that a further exploration of the therapeutic processes at these different and intertwined levels might benefit from an integrative and interdisciplinary outlook such as the one we have provided in this article. What we hope will be common to such future collaborative endeavours is a shift of focus, away from considering mainly individual deficits and abnormality, still common in much of schizophrenia research, toward a more intersubjective outlook on the preconditions of both selfhood and its recovery process. Understanding that there is a deep relation between who we are as social human beings and the dialogical and interactive context of the therapy setting might pave new avenues for a deeper and more integrative understanding of schizophrenia as well as of its treatment.

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