Dialogues in a Cuban Psychiatric Clinic[1]

Klaus G. Deissler

Personal Introduction

Working in the fields of family, systemic, and finally postmodern therapies since the mid-seventies, I have many of my closest professional friends outside of Germany and Europe. With increased globalization, one might find oneself sharing more philosophical and therapeutic assumptions with those who live far away than those nearby; at least, this has been the case for me. In this chapter, I share the history and development of my relationship with my Cuban colleagues.

I begin the story by sharing a dream that lead me to where I am today. Earlier in my career, when I worked routinely as a psychotherapist, I would dream about working for a couple of years in South Africa, a couple years in Argentina, and a couple of years in the USA. South Africa fascinated me because of opportunity to transform apartheid into a multi-ethnic community; Argentina, because of its strong European influence, especially the Spanish language; and finally the USA, which I found attractive because it was less history-bound and more open to the future than Europe. Having these simple ideas in mind, I dreamed from time to time of leaving Europe for six years to tour the world. However, I always felt bound to Europe because earning a living long-term would be restricted elsewhere.

Given these dreams, in the late 90s, I had several opportunities to spend time with a close friend, Dr. Siegfried Schulz, a veterinarian at the University of Marburg and a painter. One day Siegfried suggested that I go with him on his next trip to Cuba. He had been doing research on ozone treatment of tumors in rats, and he suggested I could come along with him

[1] Servicio de Psyquiatria Professor René Yodú,

for some holiday time. Although Siegfried painted a beautiful and colorful picture of Cuba and his work at the research institute in Havana, I was reluctant and skeptical: I did not know anyone there, I could not speak Spanish, and what would I do while Siegfried was working? I rejected his offer, but Siegfried persisted in trying to convince me. The more I resisted, the more insistent he became. Finally I said, "Okay, next time you go to Havana, bring me an invitation to teach in the university's department of psychiatry. This will allow me to work too; then we can spend some free time together." I was skeptical about the possibility, but I hoped the idea would successfully end our conversation about my visiting Cuba.

However, Cuba continued to appear in my life in other contexts. I soon learned of Ry Cooder's, a rock guitarist, engagement in Cuban music and the "Buena Vista Social Club" music group. Coincidentally, around that time, my colleague Astrid Wortmann gave me some novels written by a Cuban author, which I read with great enthusiasm.

When Siegfried returned from his visit to Cuba, he greeted me with a bright smile. "Here is your invitation", he said and handed me an invitation from the director of the University's psychiatric clinic, Prof. Dr. Reina Rodriguez[2]. I could not say "no" any longer. Siegfried spoke about Reina with enthusiasm. She had received her doctorate at the Humboldt University in East Berlin in 1984 and could, of course, speak German.

Siegfried and I started planning our trip to Cuba. I had an email exchange with Reina, and we agreed upon the seminar topics and the time of my visit. In this process, Siegfried guided me in what to expect and how to plan my visit. However, shortly after I finalized the agreement with Reina, Siegfried told me that he had changed his plan and would be postponing his visit to Cuba. I felt disappointed by Siegfried, who had pushed me to go to Cuba when I did not want to; and now that I wanted to go, he withdrew. I felt trapped: I

[2] Prof. Dr. Reina Rodriguez was the director of the «Servicio de Psyquiatria Professor René Yodú», Havana, until 2001; she is famous in Cuba for introducing new methods of group therapy in psychiatric institutions. Today she is working as a senior consultant at «Servicio de Psyquiatria Professor René Yodú, Hospital Universitario Dr. Joaquin Albarran, Habana, Cuba ».

really wanted to go but felt insecure because I did not know the country or anyone there. However, I did not want to postpone my visit because I could not anticipate the future. I finally decided on a compromise: I would go only for a week. If it was bad I only had to suffer for a week; if it was good, I could return.

I ordered my tickets and thought I could calmly plan my visit to Cuba. Then about three months before I left for Cuba, Reina asked me to bring some psychotropic medications because they needed them and could not afford it. I said, "no!" to myself: "All these years I have worked to construct alternatives to psychopharmacological treatment - especially dialogical approaches to therapy, consultation and supervision. I am not a MD. I am a psychologist. Three times no!" But I was not sure how to tell her. So I consulted friends and psychiatrists about the situation. They did not see a problem at all and counseled that I should not make it a question of principle. So I made the resolution: "Okay, as a guest, I will take them as a present to honor their request, but I will tell them immediately that my work will present alternatives to psychopharmacological treatment." I got psychotropics and put them in a rucksack in my office, and every day I looked at this strange thing waiting to be transported to Cuba.

Just as I had made peace with my plan to bring the medications, Siegfried showed me documents from Cuban customs stating that importing psychotropics is illegal. I felt desperate and did not know what to do. I decided I would request special permission from the Cuban embassy. I phoned the embassy and spoke with a friendly man who seemed to understand my problem and said he would call me back with answer. I waited and called several other times, but no answer. So the day before I left, I decided to smuggle the medications to Cuba. Strangely, after all these intense feelings of rejection, doubt, hope, desperation, I did not feel much passing the controls: just a little indolence.

After passing the control area, among the many people waiting and waving, I saw three people laughing and waving warmly towards me. They had a little board with "Dr. Klaus" written on it. They seemed to recognize me, maybe from a picture that Siegfried had shown them, at least I recognized Reina that way. We drove to Reina's home for a long night of talking and drinking. It was "love at first sight" (metaphorically speaking): we immediately liked each other and felt strongly that we could work together.

Two days later, I started my seminar with a little story about how I was invited to Cuba. While talking I thought of my dream working in South Africa, Argentina and the USA. I wondered: "Maybe in Cuba, a Spanish-speaking, multi-ethnic society with European traditions that is a stone's throw away from the USA, some of the things I have wanted to learn in these other places I can get here?"

Process and Content of the Seminars in Cuba

I believe that my work in Cuba is best described in my Cuban colleagues' words (see below). Nevertheless, I would like to identify the main influences of my work are, in historical order: the Milan systemic approach, Tom Andersen's work, Harry Goolishian's and Harlene Anderson's work, social constructionist theory (e.g., Gergen, Shotter), and postmodern philosophies (e.g. Bachtin, Lyotard and Derrida). Although personally I prefer the term "dialogic"[3], for pragmatic reasons when teaching I refer to it as Reflexive Systemic Therapy and Consultation (RST; Deissler, 1997).

Before I share the perspectives of my Cuban colleagues, I will briefly outline my work in Cuba. I have visited Cuba nine times within seven years (1999 - 2005) and have done more than ten seminars there, including several conferences. My Cuban colleagues have enthusiastically embraced the forms of practice and the ideas I presented and quickly put them into their daily routines and psychiatric practice. I have also been part of official and

[3] The guiding question for my concept of dialogic is: How to do I construct useful dialogic contexts together with clients?

unofficial meetings at the University, including participating in the inauguration of the doctorate in medical sciences and serving on the morning shift at the psychiatric clinic. Most participants in these seminars work were associated with the university and many worked in its inpatient and outpatient psychiatric clinics that serves individuals and families.[4]

When teaching, I present ideas and practices in a narrative, colloquial, and dialogic manner: mainly I tell stories and intersperse theoretical ideas and concept and I do practical exercises and presentations. This becomes an intense way of dialoguing about and experiencing these ideas. Topics that I presented in Cuba included the following, with some formally planned and others improvised:

- History of family therapy, systemic therapies and postmodern variants
- Epistemological/Poietological[5] (Deissler, 1989) ways to understand what therapists/consultants do
- Objectivism/realism/rationalism
- (Radical) constructivism, (social) constructionism, postmodern ideas
- The classical way to work with a "reflecting team" (Andersen, 1990)
- Reflexive Systemic Therapy (Deissler, 1997)
- Postmodern practices, e.g. "as if position" (Anderson, 1997) and "improvisational role-play" as reflecting process and as a form of self-reflecting for collaborators in psychiatric contexts.
- Therapy, consultation and supervision as "forming dialogical ways" to dissolve "problems" (Deissler, 2000).
- Philosophical stances/attitudes of therapists and consultants (Anderson, 1997)
- Appreciative Organization[6] (Anderson et al., 2001).

[4] (Servicio de Psyquiatria Professor René Yodú, Hospital Universitario Dr. Joaquin Albarran, Habana, Cuba).

[5] How do we know, what we know/how do we construct, what we construct?

In each seminar I did three to five "reflexive live-consultations" (Deissler & Schug, 2000) with clinical situations presented by my Cuban colleagues. These occasions offered the opportunity to demonstrate how different ways of talking simultaneously imply different ways of listening. I talk about these different ways to talk and listen as "polyphonic ethics." This means that this dialogical approach is "multi-vocal and multi-aural," creating a new form of collaborative ethics, which opens up a space for new understanding and possibilities.

An important contextual factor in these visits was that in Cuba there is no pharmacological industry, so medication is a minor part of the practice of psychiatry. From my perspective, in Cuba the field of psychiatry and mental health is in a fortunate position: they have to think about and use different treatment approaches other than medication. Perhaps this necessity is why Cuban psychiatrists have been more receptive to dialogically oriented forms of therapy and consultation than those in other countries. This is in marked contrast to psychiatric contexts in Germany, where patients often seem to be reduced to packages of data that get analyzed, stored and sometimes treated: the data, not the patients[7]. What is lacking are therapists who feel touched by the stories of the patients. The professionals often seem to be in the position of "untouchable knowledge." What I saw in Cuba was an extremely cordial, warm, and understanding way to relate to patients. Maybe if we learn from Cubans cordiality and they learn from us the philosophical stance of "not knowing" (Anderson, 1997), we will both arrive at what Anders Lindseth (2005), a Norwegian philosopher, calls "not knowing, being touched."

Interview with my Cuban Colleagues

[6] Together with Karl-Heinz Kose, Dipl.-Psych., Braunschweig.

[7] I do not want to do injustice of people whom I know work differently... I am just describing a tendency.

Recently, I interviewed four of my Cuban colleagues[8] to learn about their experience of the seminars and the work that I had been doing with them and their clients. Such interviews are part of reflexive work, allowing me to better understand how my work and ideas have been helpful or not. The interview took place at the university hospital in September 2005.[9] Rather than present the interview in chronological order, the text of the interview is organized by theme to facilitate easier reading. Dingbats indicate a new section of the interview about the same topic.

Changes in Approach to Treatment

Klaus: What were the main theoretical and practical changes in your daily work [since my visit 7 years ago]?

Maria Eugenia: Theoretically, our work has been based on Marxist social psychology…. I think that your work has allowed us to take new aspects of communication into consideration and work with greater depth. For instance, the interventions we have used with families in group therapy have been very helpful for the families, the groups and for ourselves.

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Maria Eugenia: This style of therapy has been very useful; it has allowed us to improve the quality of our work. It has allowed us to continue to develop our own theoretical

[8] The interview includes the following colleagues:

- Dr. Magalis Alejandra Martínez Hurtado, Professor for Psychiatry, specialized in Social Psychiatry and Drug Addiction, director of the psychiatric clinic Joaquin Albarran hospital (successor of Dr. Reina Rodriguez),
- Dr. Elsa Araujo Pradera – Professor in Psychiatry, Group Therapist, Director of the day clinic. She is working on her masters degree in Psychology at the University of Havana.
- Dr. María Eugenia Lánigan Gutiérrez and
- Dr. Isabel Caraballo Pons are Clinical Psychologists specializing in Psychiatry, and Assistant Professors in Psychology; they work at the psychiatric clinic as group therapists.

All four of them are teaching in the new course of Family and Family Therapy at the clinic.

[9] I prepared ten questions, which were translated by Maria Teresa Ortega Sastriques who was the translator in the interview and the last six seminars conducted in Havana.

perspectives, and the practice has positively caught the attention of our professional colleagues, bringing more patient and family referrals.

Elsa: The influence of the RST has permeated all our areas of service. We are working from this approach with individuals, couples, families and groups and with a variety of very difficult problems such as addictions and, psychosomatic disorders. From a practical aspect, it is comfortable and much easier to work without the pressure of feeling that we know must have answers for everything. Instead, there are constant surprises in almost every session. We have gotten used to listening, to being open to the "new." As therapists, we feel more comfortable with sharing responsibility for the process, enjoying the conversations, and above all collaboration with patients and co-workers. From the theoretical aspect, we have been able to connect with various perspectives such as constructionism, constructivism, postmodern ideas and narrative therapies.

Isabel: Maria Eugenia said earlier that we came from a Marxist psychology orientation. Elsa says that we Cubans have been intrusive and directive. Without denying this, I want to stress that in recent years there has been an evolution in our country. Of course many still practice psychoanalysis, but more recently some psychiatrists have become interested in systemic therapies. Some had moved from an interpretative to existential perspective (working with emotions in the here and now). As these shifts were already underway, it was natural that we were receptive to Klaus's RST approach.

Affect on Personal Lives of Therapists

Klaus: Is there anything you want to say about the effect these changes had on your personal life?

Maria Eugenia: Sure. For instance, I feel that the communication with my daughter, a teenager going into adulthood and struggling with the all the complexities of that stage of life--intra-familiar relationships in general and all the trials common to living with others--has improved. I realize that approaching things from a more conversational position proves to be useful, beneficial, lowers tensions, and makes relations flow easier.

Elsa: Well, my personality and style have changed dramatically. I used to be very incisive, very intrusive, very directive, very impetuous. Now am much more relaxed, soft, open to change and tolerant—these are changes noted by my co-workers and me.

Patient Response

Isabel: I would like to add that our clinic…has always tried to not have patients feel that the therapist is in a position of having the absolute truth. When we started the seminars with Klaus, we began to apply it with patients who had experienced prior treatment, both group and individual, and had complained of lack of problem resolution. We explained to them that it was not because the treatment was good or bad that there was a lack of progress but because the therapists put them in a position of resistance (using psychoanalytic terminology) or, in our terms, "a position of no change." The experience proved very interesting, the patients felt different.

Klaus: In what sense did they feel different?

Isabel: In the first place, they felt accepted. They felt that they could agree or disagree with us because ours was not the only truth. They could choose to accept our premises, having that choice made them in our eyes, non-resistant. Instead, they were exercising a choice.

Ethics of Respect

Maria Eugenia: One of the reasons I think this technique was well received … has to do with the ethical component. Patients and families felt they were treated with respect. It is very important for people to feel respected. I think it was also useful for them because it involved a learning process, as they strove to be heard, they learned to hear themselves.

Isabel: Following Maria Eugenia's line of thought, the patient's relatives almost always think or feel guilty for what is going wrong with the patient or treatment, which affects the communication, its quality, its flow. Now when we use Klaus's approach the relatives feel comfortable, are cooperative, and often when the patient completes treatment one of the relatives goes into treatment for his/her own development.

Elsa: Definitely we Cubans had a way of doing therapy. We were very intrusive, incisive and directive. Our therapy has changed to a more colloquial language, to a relationship where the consultee feels highly respected. We do not impose dialogue, we share it; this extends to our relationships with colleagues and at home.

Perception of and Working with the Patient's Family

Maria Eugenia: The only thing I would add is that the perception a therapist has of the patient is not the same as the perception he or she has of the patient's family. That is, we try to keep in mind that each family member is different from the others.

Klaus: How do you see them as different?

Maria Eugenia: When we have a patient, we now say this person has a "perception" about the family. If, for instance, a patient describes her husband, we do not pass him through a filter to see if he himself has disorders based on her description. With the family, maybe due to cultural problems, we maintain much stronger affective ties. The

perception is different; it is what we know as "catatimia," distortion of perception due to affection.

Elsa: I think it is much easier to dialogue with the family starting with tentative comments such as, "maybe" or "I might be wrong but I feel that…." Where as in the past I might have closed off the possibility of dialogue if I began with words or attitudes that might have invited resistance or a fight with the family. Having doubt in the air, indicating that I am not quite sure, or I do not have the "Truth," provides openings that promote the flow of dialogue not only in therapy but in our personal lives as well.

Magalis: Working in this way has allowed us to incorporate relatives in the therapy that we otherwise would not have considered including. We used to work only with closest relatives: the spouse, a parent, and maybe one of the siblings. Now we have expanded our idea of the family; we talk with members that were never listened to before but who are definitely important in the patients' lives.

Maria Eugenia: I am talking about perception, how one perceives the patient, the family, even how one perceives her own family. I think that this procedure with the family is a predictive indicator. For instance, many times it is not the identified patient who really needs the consultation. When the family interacts this way, that is, through conversation, where nobody feels guilty for some one else's disorder, as Isabel said, it helps us therapists to realize how and how much each family member contributes to things not working. Sometimes we realize that the "patient" is not necessarily the one most urgently in need. And it has happened that applying the technique has made the ones in need realize it.

Shift Away from Expert Position

Isabel: This way of dialoging has contributed to a richer dialogue between therapists because we do not have to demonstrate our expertise. This liberates us from having to be exact or say the correct thing. In other words, we do not contribute more than the patients and their families; we equally contribute to the dialogue and it is a more human and richer one.

Applications in Training and Supervision

Isabel: We have used this approach not only with medical cases but also with students. It's a didactic tool that promotes communication with and among them.

Isabel: I think it is important to add that this form of therapy has also been used in our supervision. Our colleagues come to train in the modality of psychotherapy that we practice. This has allowed our colleagues to observe us and understand what we do. This has served as a kind of supervision for us. This experience has been very important because we do not have a practice of supervision here as they do in other countries.

Applications Outside of Therapy

Elsa: Rosario and I used the technique to help improve the communication and reduce violence and stress among taxi drivers at a base near the zoo.

Klaus: What do you mean by "technique"…? (Laughs)

Isabel: The way of doing things.

Klaus: Yes, but, the way of doing what? How did you do it?

Elsa: The same way we do it here with the families …

Isabel: … favoring the dialogue, so they can learn to listen, so all that is said, independently of who says it, is valid because it is an alternative. Because nobody has the absolute

truth, but everyone always has something valid to say. And the way we have intervened or coordinated has facilitated the problem resolution.

Elsa: For instance with the taxi drivers, first we created a group with the taxi base supervisors, another group with union members and another one with the workers. We listened to each group; then we did reflections on each group's narrations. We acted as coordinators or moderators not expert problem solvers, and the workflow improved.

Isabel: I think the situation undoubtedly has changed; it was enriched, and they discovered more possibilities for their situation.

Medication

Klaus: What have been the main effects on patients in terms of medication, days of stay in the hospital, quality of professional collaboration? Do they like the new way of working?

Isabel: In our group, our patients stay on medication the first few days then we suspend the medication. As the patient gradually gains the capacity to reflect and change, the need of medication diminishes. In our work, from individual to group, most people come to us more in search of psychological treatment than medication. I believe the same occurs to Magalis and Elsa. Most patients improve without medication; some resolve their problem after two or three sessions.

Elsa: Rosario and I work mostly with families, and we have seen dramatic improvement in patients treated with RST allowing us to reduce medication dosage. I cannot give percentages nor establish clear causality, but the advantages are evident to us. We have been able in many situations to avoid the need of hospitalization and reduce or even eliminate medication.

Magalis: We have not done any research nor do we have quantifiable data, but, without a doubt, we have observed two phenomena: reduction in hospital stays and in use of medication. We work with patients in acute states, drug users, and suicidal persons. With the new technique, they are out and recover earlier.

Maria Eugenia: In my experience patients with neurotic or dystimic disorders need less medication [using this approach]. They also request the involvement of their families in therapy.

Klaus: How do you understand the decreased need for medication and the request for family members involvement in treatment? Are the two related?

Elsa: We have had patients to whom we have proposed this new dialogical way of working. We tell them it is a new way to converse and that it works better without medication so they can have clarity to listen what is said. Because they become interested in this new way of conversing, many reduce their medication dosage. For instance, Rosario and I had a case of bulimia that we initially treated using traditional systemic therapy with the family; we had to hospitalize and medicate her. When we shifted to the RST approach, we no longer had to hospitalize her and reduced her medication to a minimal dosage.

Work with Children and Adolescents

Isabel: Sometimes, due to special circumstances, we see adolescents and children although that is not common practice. Some of them we see not so much as patients but youngsters to coach for school issues, career orientation or handling family conflicts. RST has been very useful for these cases; the youngsters have felt listened to. I do not have statistics on this issue but a strong and hard-felt observation.

Cuban Cordiality and Spontaneity

Klaus: How does Cuban cordiality and spontaneity fit with dialogic therapy?

Maria Eugenia: I think it [this approach] has been easy for us; it comes naturally. On the other hand we are culturally impatient, trying to squeeze out words from patients' mouths, so we have to make an effort to let patients say, and more importantly finish, what they want to say. So we do train harder on the timing of interventions to fight that natural [cultural] impatience.

Isabel: I know every therapist needs training in the technique he is going to use, to feel comfortable using it, to adapt his personal style to it. Now thinking as a Cuban as well as therapist, I think Cubans are naturally very communicative, talking comes easy to us; listening, being open to others' thoughts, and appreciating others' truths are harder for us.

Maria Eugenia: I agree, we do have as a common characteristic difficulty listening.

Isabel: Maybe we have a hard time listening because we are so passionate, emotional, impulsive and temperamental. But, of course, we can learn!

Magalis: Cuban traits affect not only our approach as therapists but the ways of our patients and their families. For instance, when we meet an atypical [Cuban] personality or an outsider such as Klaus who is an impressive figure, it brings a sense of fear and inhibition. However, despite these fears, the approach has been successful. It has opened up to us and our natural spontaneity and sociability, having more than compensated for our also natural (but controlled through training) impulsiveness.

Compatibility with Communism

Klaus: How do dialogic, systemic and social constructionist ideas fit with communist ideas?

Isabel: Reading this question, it seems to refer to the philosophical position underlying each psychotherapy approach. I don't think this is a question to tackle quickly; actually, I would propose it as ***the subject*** of our next seminar (laughs). I think a seminar about

the theoretic constructs that inform this therapy and the philosophical position that informs our ways of acting would be a good subject.

Klaus: What I didn't say but assumed is that if you do not want to respond, then don't.

Isabel: Clear enough.

Klaus: This interview will be published in the U.S., so it up to you to respond.

Isabel: That is not the problem, not the publication nor where it will be published. We know we have the option to respond or not. We are giving the question the importance it deserves; it is not a question to be taken lightly. Maria Eugenia talked about our professional background and our limited exposure to psychological theories. We are trained as medical doctors and have been feeding our need to learn about the field of psychology. We are interested in learning about the scientific and ethical issues related to this work. So for me, the question is interesting and important, tackling it would add to our theoretical knowledge, therefore the request to do a seminar (laughs).

Maria Eugenia: I completely agree with Isabel on our need for more knowledge on theory about constructionism. I think we have a grasp of the practical concepts but not as fully the theory that sustains them. We need to know more about social constructionism and postmodernism. However, I think I can respond to the question based on a reflection I made on the relation that could exist between dialogic, social constructionist, and systemic ideas and communist ones. I think the common link could be the *social*. This question relates to a prior one on how we adapt the new ideas to our culture. So I think the common link is, from an ideological point of view, the social aspect. [10]

Cuban Innovations

John Lannaman asked the following question at a panel of a conference in Svolvaer, North Norway in 1993: "Why shouldn't we abbreviate 'socialconstructionist' and call it 'social(construction)ist'?"

Klaus: What are your own contributions/transformations to the dialogic way of speaking and listening to patients? What are your perspectives and future projects?

Isabel: Well, as we were introduced to this form of therapy and applied it our work, lets say we made some modifications or innovations, because we are using our patients to form the reflecting team. We train them in how to work with our therapeutic model, and this is a modification, and so far everything has gone well and has been very productive.

Klaus: I learned about your modifications two or three years ago. Have you brought in more than one full family so these families can form reflecting teams for each other?

Isabel: We invite them as a matter of course to our group. The families can, at a given time, form part of the reflecting team in relation to other families; even the patients join the reflecting team because the model allows for patients to function as co-therapists.… it flows very well. This is something we did without the professor's permission (laughs)! But it has been a very good experience; at least the patients have said so. We will continue to work this way. We have to write about it; we need to leave a written record of this practice.

Klaus: I'm waiting for the article to be written and translated into German.

Isabel: Well, it is being written, but it is not yet translated (laughs). We have it pending; actually we are doing it with our pupils, and it is coming together. Now that I am changing jobs, I am thinking of taking it with me as a new modality there.

Maria Eugenia: A contribution that we have made is to take our new approach to working with families and bring it to our group work. When we work with families in a group, the patients, together with us, became the reflecting team; therefore, the reflecting team is made up not only of professionals. This not only contributed to the therapy

process but also enriched our work and made it easier. We've also done individual sessions during the group and are trying to use theatrical improvisation with them. We hope in the future to do improvisational therapy with families.

Future Possibilities: Community and Beyond

Klaus: What about other projects you plan to do? Do you want to answer this question? (Laughs) Then you can refer to it…

Isabel: (interrupting): …Is she going to do a doctorate on RST? (Laughs)…

Klaus: …On what you said about the taxi drivers as well as other applications. Could you also talk about the project of the "reference center"?

Elsa: Entschuldigung?! [German for "Pardon me"?!][11]

Klaus: I am not trying to correct you; I just want to insist a little …

Elsa: As we explained, this was a job done for the taxicabs company as part of our community service using the "appreciative organizations" approach we learned from you. We also applied this approach in a very tense, problematic situation at the women's center. The scope of our work is extending beyond traditionally working with only patients and their families. As part of my masters in clinical psychology degree, I am studying RST with families and have used it with 22 families having various problems. We had very good results.

Klaus: Would you like to add anything you think is important for you?

Elsa: As part of this research, I plan to do a project with a larger sample of families over a longer period of time and introduce variables in the study such as the use (or not) of psychotropic medication, dosage, hospital stays, etc. I plan to use a control group so I

[11] One day when I came back to Cuba for a seminar again, I was surprised and felt touched when all participants stood up when I entered the room and they said something like: "Guten Morgen, Herr Professor Klaus!" ("Good morning, professor Klaus"). This was also a very funny scene because I never had such an experience before, but I was very impressed by the fact that all the members of the seminar took some German lessons.

can compare results. Additionally, I feel that the theoretical-practical training we have received from Professor Klaus has been very important, not only because of the personal impact on each of us but because it allowed us to develop a very useful tool. And in my case, having been working as a therapist for a long time in the acute unit and then alternating as a family therapist and now as a group therapist, I feel this is a tool useful in all circumstance and all forms of treatment. It is said that one does not really have the knowledge until one is able to verbalize it, and so we mustered the courage to give a course on family therapy where the "main dish" was RST. So we have been able to train other therapists from other institutions in this systemic modality. With this therapy, we are providing service of high quality and ethical value, and I think this is very important due to the demand for assistance in this population, not only in quantity but also in quality.

Maria Eugenia: I think we should mention something about the applicability of this therapy in the community. After the taxi company experience, we said why not use the dialogue approach with other community institutions? I think it has many applicable variants.

From a Medical to Psychological Perspective

Elsa: I definitely think this is a very new approach, not only in terms of quality of participation but also in terms of conceptualizing illness. As such, diagnosis has lost its ontological privilege[12]. The patient is no longer viewed as a sick person with pathology and instead is viewed as a person involved in a plot of family relationships

[12] What Elsa means by "ontological privilege of diagnostics" can simply be put like this: In classical medical thinking and practice there is a rule that says: "before treatment God put the diagnostics." In dialogical (communicational, social constructionist) contexts it seems to be different: the way you talk with each other creates the reality, e.g. a diagnosis.

and personal constructions. This is critical to me because before the dialogue was centered on the dysfunction and illness.

Maria Eugenia: I'm thinking that without us consciously trying we have been moving from a medical model to a psychological one, that being the contribution that this therapy has done for us …

Isabel: …to the point that many people (not patients) who contact us do not think we are psychiatrists; they say we are psychologists, and they do so based on the discourse (laughs). We constantly have to say, well, we are a little of both, don't you think? The distinction is our way of conversing.

Magalis: Each of us has identified our future project because obviously an internal shift is occurring that is changing each of our perspectives. In order to involve the community, we need to involve our colleagues with a job profile that is fundamentally community oriented. The relationship and communication with our primary care areas is changing, and we are using new forms of dialogue with them, moving away from confrontation to collaboration. This in itself is a new project, even if it is not written on paper yet, and we have been doing so for years. Something new this time in the seminar is that we asked Klaus for what we wanted. Before he has come prepared with his ideas for the seminar. Now we are asking in advance; we are progressing.

Influence in Cuba

Isabel: We act as a "reference center" for this type of therapy. We continue to grow through this annual training with Professor Klaus. This service has opened a new form of treatment for families in the acute unit.

Magalis: This approach has started to move beyond our walls, and we have taken our experiences to international conferences in our country. Recently we attended one in which Klaus participated with us in seminars and presentations. Next March, we plan

to participate at an event organized by the Society of Child-Youth Psychiatry, which will provide another opportunity to share our group's work. We have to mention here our next meeting with Klaus will be different because we will have guests that will hear about what we are doing and will share what they do.

Klaus: Any additional issues?

Elsa: Beyond theory, when a treated family brings another and that one brings another and so on, extending the chain of families, this happens not because we announce ourselves but because the families appreciate and recommend us. This is the best proof of success and usefulness of this therapy. Meeting Klaus, in addition to the opportunity to meet an excellent human being, introduced us to a new modality of therapy and the postmodern movement in psychotherapy and allowed us to delve into philosophical issues that we don't frequently address, but should. This has also allowed us to work under his supervision, which we value highly.

Isabel: One more thing: we have participated in many events and learned from the experiences of our colleagues, but with Klaus we actually had the opportunity to experience the process with families under his supervision.

Elsa: Something that just occurred to me is the impression we made on visiting colleagues who were very positively surprised by the work we do. Let me share an example: We had a woman from a family of seven, a very neurotic woman. When we ended the session, I asked her what title would she choose for the story she had told abut the family, like a movie title. She thought for quite a while and came up with a very long very dramatic title, something like "My family going through life's diatribes with me at the center the storm." I responded, "That is a title worthy of a Soviet export film." This woman, who seemed very angered during the session, got quiet and thoughtful

and stared expectantly to the rest of the family; the family broke into loud laughs, which ended with her laughing too.

Isabel: The question would be: is it the title or the script?

Klaus: What happened after they laughed?

Elsa: I closed with that because of the symbolic force; so I said: "I invite you to have a new conversation in a month." And they did appear the following month. We have had five sessions with them so far. They have many, many issues. There are three generations in this family.

Klaus: Let me thank you enormously. It has been a very rich and exciting interview, which I truly treasure. I wish I had it written on paper already, I'm scared losing it. I will be very careful to have it transcribed as soon as I reach Germany. I was thinking of my Spanish colleague Gema Carbajosa[13], she is the one who should do the translation.

Future Projects and Perspectives

The continuation of the seminars suggests itself: There will be a deepening of the presented topics and new and different topics will be added. For example, we may add questions of teaching, supervision, consulting with other institutions, research projects, publishing articles, conducting seminars together and mutual visiting of the collaborators of the institutions are intended. All this will be embedded into the collaboration between the "Marburg Institute"[14] and "Servicio de Psyquiatria Professor René Yodú" in Havana. A contract between the two partners is on the way. Finally, the two partners will support the building and official sanctioning of a "Reference Center for Systemic and Postmodern Therapies and Consultation," allowing the dialogue to continue for years to come.

[13] Gema Carbajosa, Dipl.-Psych. transcribed the interview in Spanish and translated it together with me into German.

[14][14] http://www.mics.de/

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