Inner and outer voices in the present moment of family and network therapy

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Dialogue in the polyphony of inner and outer voices in the present moment of family therapy is analysed. In Western Lapland a focus on social networks and dialogues in the meeting with families has proved to be effective in psychotic crises.

Introduction

In this paper three main themes are considered. First, I analyse the importance of the present moment in family therapy. Second, I explore the polyphony of voices as the main aspect of human psychology and its meaning for family therapy dialogue. Third, the effectiveness of dialogism in the treatment of psychotic problems will be illustrated in the province of Western Lapland in Finland.

The present moment

Open dialogue describes both organizing the psychiatric practice for severe crises and dialogues in meetings with the family and the rest of the client's social network. For therapists the main challenge becomes being present and responding to every utterance. We are living in the 'once occurring participation in being' (Bakhtin, 1993).

Tom Andersen (2007) was preoccupied by three different realities of our practices as clinicians. In the 'either–or' reality we handle issues that are visible but dead in the sense that they are exactly defined and the definitions remain the same in spite of the context. In the 'both–and' reality we deal with issues for which many simultaneous descriptions are possible. These issues are living and visible. This is the case, for instance, in the family therapy discussion when we make space for different voices to become heard without considering one point of

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view to be right and another wrong. The most interesting may be the 'neither–nor' reality, in which things are invisible but living. We experience something as taking place, but we do not have an exact linguistic description for it. We may say that it is neither this nor that, but I know that something is taking place. As an example, Andersen gives handshaking. It is something that happens in our embodied participation in the session, yet it is not commented on by words but remains as our embodied experience of the present moment.

Daniel Stern (2004) in emphasizing the importance of the present moment is critical of descriptions of psychotherapy and psychoanalysis that focus on clients' narratives. The therapist is seen as the one giving meanings to patients' stories, in different schools in different ways. Therapy deals with explicit knowledge in linguistic descriptions. Stern proposes moving from explicit knowledge to the implicit knowing that happens in the present moment as embodied experience, and mainly without words. We live in it. The present moment is a short one, varying between one and ten seconds, lasting on average three seconds.

Stern is describing individual psychotherapy. In the type of family therapy that focuses on generating dialogues this means shifting the focus from the content of narratives to the present moment when narratives are told. Therapists and clients live in a joint embodied experience that happens before the client's experiences are formulated in words. As in dialogue on the whole an intersubjective consciousness emerges. Our social identity is constructed by adapting our actions to those of others. For Bakhtin, knowing myself is only possible by seeing ourselves through the eyes of the other. I see myself through others' eyes (Bakhtin, 1990). In Bakhtin's view if we want to see ourselves as living persons while looking at our reflection in the mirror, we adapt others' eyes to do that. Living persons emerge in real contact with each other and adapt to each other as in a continuous dance in automatic movements without controlling their behaviour in words.

Intersubjectivity

The intersubjective quality of our consciousness is shown in the mother–baby communication studies conducted by Colwyn Trevarthen (1990). Trevarthen's careful observations of parents and infants demonstrate that the original human experience of dialogue emerges in the first few weeks of life, as parent and child engage in an exquisite dance of mutual emotional attunement by means of facial

expressions, hand gestures and tones of vocalization. This is truly a dialogue: the child's actions influence the emotional states of the adult, and the adult, by engaging, stimulating and soothing, influences the emotional states of the child. Bråten (1992, 2007) describes the Virtual Other as an innate part of the baby's mind that in a way waits for a dialogue with the Actual Other. If the Actual Other is not present, the dialogue emerges with the Virtual Other. Near relations take place in the mode of felt immediacy, in feelings that are felt in a pre-linguistic form. David Trimble has been analysing the importance of Trevarthen's and Bråten's studies for family and network interventions (Seikkula and Trimble, 2005).

In every meeting two histories happen. The first is the history generated by our presence as embodied living persons. We adapt ourselves to each other and create a multi-voiced polyphonic experience of the shared incident. Salgado and Hermans (2005) point out that we cannot call this 'experience', because experience already presumes psychological meaning that is included by the Other or Otherness in the situation. It is our embodied experience for which manifold meanings emerge based on the number of participants in the situation. Family sessions as such already include several family members and often two or three therapists. Most of this history takes place without words, but not all. The words that refer to our presence in this conversation often include the most important emotions connected to those voices of our lives that deal with difficult experiences. We may, for example, describe and reflect on our feelings about the specific situation we are talking about.

The second history in the same situation occurs in the stories that living persons tell of their life. Stories always refer to the past, they never can reach the very present moment, since when the word is formulated, and when it becomes heard, the situation in which it was formulated has already passed. Integrating the two aspects of the same moment it becomes evident what focus on dialogue can add into narrative orientation. While comparing narrative and dialogical approaches in family therapy, Roger Lowe (2005, p.70) stated that:

> The conversational style . . . simply follows the conversation, while the narrative and solution-focused styles often attempt to lead it. The conversational style strives to remain dialogical, while the solution-focused and narrative styles may become monological (e.g., when therapists attempt to 'story' clients' lives according to a planned agenda).

Compared to narrative and solution-focused therapies, in dialogical approaches the therapists' position becomes different. Therapists are no longer interventionists with some preplanned map for the stories that clients are telling. Instead, their main focuses on how to respond to clients' utterances as answers are the generators for mobilizing one's own psychological resources, since 'for the word (and consequently for a human being) there is nothing more terrible than a lack of response' (Bakhtin, 1984, p.127). Respecting the dialogical principle that every utterance calls for a response, team members strive to answer what is said.

Answering does not mean giving an explanation or interpretation, but, rather, demonstrating in a therapist's response that one has noticed what has been said and, when possible, opening up a new point of view on what has been said. This is not a forced interruption of every utterance to give a response, but an adaptation of one's answering words to the emerging natural rhythm of the conversation. Team members respond as fully embodied persons, with genuine interest in what each person in the room has to say, avoiding any suggestion that someone may have said something wrong. As the process enables network members to find their voices, they also become respondents to themselves. For a speaker, hearing her own words after receiving the comments that answer them enables her to understand more of what she has said. Using the everyday language with which clients are familiar, team members' questions facilitate the telling of stories that incorporate the mundane details and the difficult emotions of the events being recounted. By asking other network members' comments on what has been said, team members help create a multi-voiced picture of the event.

When the team is not present

To illustrate the importance of the once occurring event of being, a transcript of a therapy session is given. Pekka (P) had been hospitalized after a home visit that the crisis intervention team had made the previous week. In the meeting it appeared that P had been violent towards his mother. In the following sequence, this occasion is described. T1 and T2 stand for the two therapists.

> **T1:** *I thought that it happened during the last two weeks, not before.*
> **T2:** *Was it a threat or even worse?*
> **T1:** *Hitting, I thought that P hit his mother.*

T2: Was P drunk or did he have a hangover?
 P: No, I was sober.
T2: Sober.
T1: I understood that P had tried to ask his mother something?
 P: Well, it was last weekend; the police came to us. She was drunk. When she didn't say anything and started to make coffee in the middle of the night, and I asked . . . I went out and came into the kitchen, and she turned round and said that I wasn't allowed to speak of it. Then I slapped her. She ran out into the corridor and started screaming. I said that there is no need to scream, why can't she tell . . . . And then I calmed down. At that point I got the feeling . . . . And the police came and the ambulance. But in some way I have a feeling, that it is, of course, it is not allowed to hit anyone. But there are, however, situations . . .
T1: Was that the point when you went into primary care?
 P: Yes it happened just before that.
T2: Why didn't she say that the police came round?
 P: What?
T2: Why didn't she say that police had been at your place the previous night?
 P: It wasn't the previous night, it was last weekend. I was thinking, all the time I am thinking these strange things and I knew that they were not true. But when you think about them for a while, after that you have the feeling that things like that can really happen. It is too much . . . .All you can think about are all kind of trifling matters.
T2: And it all started last weekend, this situation?
T1: Yes.

When the patient was describing the situation in confused language, unable to use unambiguous description, he ended by saying, 'it is not allowed to hit anyone'. He had an origin of an inner dialogue to deal with what he had done. But the team did not respond to this, instead continuing to question him about how he contacted the healthcare system. Team members actually focused in on the content of his story of what had happened instead of being present in the very moment and answering Pekka's reflections of his own behaviour. This was not an isolated example, given that in the next utterance, when the patient continued his self-reflection on his 'strange things' (meaning hallucinations), the team did not help him to construct more words for this specific experience he was speaking about. In this short sequence there were two utterances, which were not answered,

and in which the team members focused more on the story than on the presences and consequently no dialogue emerged. The case is described in a study (Seikkula, 2002), in which it was found that not responding and thus helping to generate dialogue in severe psychotic crises can actually be related to generally poor outcome in the treatment.

Polyphonic self – voices

Seeing our consciousnesses as intersubjective abandons the frames of looking at individuals as subjects of their lives in the way that the coordinating centre of our actions would exist within the individual. Instead, a description of the polyphonic self is generated. This is the core content of Bakhtin's work, but he was not the first one to speak of the polyphonic self. In fact, Plato in his early works saw self as a social construction. He said:

> When the mind is thinking, it is simply talking to itself, asking questions and answering them, and saying yes or no. When it reaches a decision – which may come slowly or in sudden rush – when doubt is over and the two voices affirm the same thing, then we call that 'its judgement'.
>
> (Plato, *Theatetus*, 189e–190a)

The mind is voices speaking to each other; it is an ongoing process of dialogues instead of looking at one core self. What we name as personality and psychological being takes place in this inner conversation between voices. Voices are the speaking personality, the speaking consciousness (Bakhtin, 1984; Wertsch, 1991). Personality is not a psychological structure inside us, but actions that happen in speaking, and in this way the human consciousness is generated. Stiles (2002) has tried to operationalize the idea of voices by noting that 'Voices are traces and they are activated by new events that are similar or related to the original event' (p. 92). All our experiences leave a sign in our body, but only a minimal part of these ever become formulated into spoken narratives. In formulating these into words they become voices of our lives. Instead of speaking of unconsciousness into which those experiences and emotions that we cannot deal with are repressed, it is more accurate to speak of non-conscious experiences (Stern, 2004). When experiences are formulated into words, they are no longer unconscious (Bakhtin, 1984).

There is not only one form of polyphony, but words that are spoken openly and in inner dialogue mean different things for our therapy
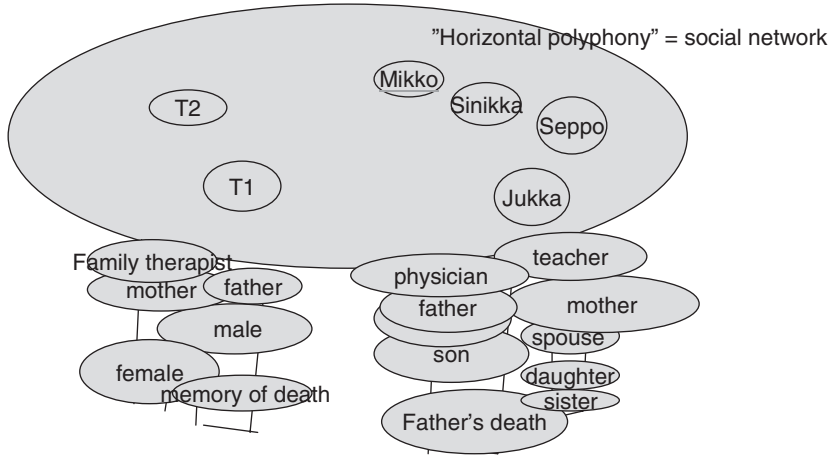
Figure 1. Illustration of horizontal and vertical polyphony

session. Psychologist Kauko Haarakangas (1997) described horizontal and vertical polyphony (Figure 1).

The horizontal level of the polyphony includes all those present in the conversation. A kind of conversation community is generated. Everyone has its own voice and if we want to mobilize the psychological resources of each one present, everyone should have the right to utter them in their own way. Figure 1 illustrates a case. Father Pekka was referred to psychotherapy owing to his deep depression that had led to a severe suicide attempt. His wife and two adult sons were present. The richness of the family therapy conversation becomes evident if we focus on those voices that are not seen but are present in each one's inner dialogues. These voices of the vertical polyphony become 'switched on' depending on themes of dialogues. In this case Pekka was occupied by his job as a doctor, because he had difficulties taking care of his duties. He was also occupied by his marital problems, by being a father to his two sons and especially by his own father and his memory. The memory of his father was actualized even though his father had died when he was only 10 years old, forty-five years ago. In Figure 1, an illustration is given of the voices of Pekka and his wife Liisa.

Important aspects of the polyphony are the voices of each therapist. Therapists participate in the dialogue in the voices of their profes-

sional expertise, being a doctor, psychologist, having training as family therapists and so on. In addition to the professional voices, the therapists participate in the dialogue in their personal, intimate voices. If a therapist has experienced the loss of someone near to her, these voices of loss and sadness become a part of the polyphony, not in the sense that therapists would speak of their own experiences of death, but in the way they adapt themselves to the present moment. How they sit, how they look at the other speakers, how they change their intonation and so on. Inner voices become a part of the present moment, not so much of the stories told. Therapists' inner voices of their own personal and intimate experiences become a powerful part of the joint dance of dialogue.

Main elements of open dialogue meeting

The activity of constructing new shared language, incorporating the words that network members bring to the meetings and the new words that emerge in the dialogue among team and network members affords a healing alternative to the language of symptoms or of difficult behaviour. It is the task of the team to cultivate a conversational culture, which respects each voice and strives to hear all of them.

The meetings are organized with as little preplanning as possible. One or more team members act as host for the meeting. With everyone sitting together in the same room, in the beginning, the professional helpers share the information they may have about the problem. The one in charge then offers an open-ended question, asking who would like to talk and what would be best to talk about. The form of the questions is not preplanned; on the contrary, through careful attunement to each speaker, therapists generate each next question from the previous answer (e.g. by repeating the answer word for word before asking the question or by incorporating into the language of the next question the language of the previous answer). It is critically important for the process to proceed slowly in order to provide for the rhythm and style of each participant's speech and to ensure that each person has a place created in which he or she is invited and supported to have his or her say. As many voices as possible are incorporated into the discussion of each theme as it emerges. Professionals may propose reflective conversation within the team whenever they deem it adequate. After each reflective sequence, network members are invited to comment on what they heard. When closing the meeting, the participants are encouraged to say if there is something they want to add.

Each meeting concludes with a summary of what has been discussed and what decisions have been or should be made.

After team members have entered the conversation by adapting their utterances to those of the patient and her nearest relations, the network members may in time come to adapt their own words to those of the team. If one discovers that one is heard, it may become possible to begin to hear and become curious about others' experiences and opinions. Together, team and network members build up an area of joint language, in which they reach agreement about the particular use of words in the situation.

Effectiveness of open dialogues in the treatment of psychosis

Dialogism is the basic quality of the psychiatric system in the Finnish Western Lapland. To make it possible, some basic principles of the treatment may be defined. The treatment should (1) start immediately after contact with the psychiatric unit in the province. The first meeting should be organized within twenty-four hours after the contact. (2) The social network should be included in every case from the very beginning for the entire treatment period. (3) Treatment response should be adapted in a flexible way to the varying and unique needs of each family. (4) Psychiatric units should guarantee the responsibility and psychological continuity by mobilizing a case-specific team for each process. This team takes charge of the entire process for as long as necessary, both in inpatient and outpatient settings. (5) By increasing safety during the first days of the crisis it is aimed at increasing resources for tolerating uncertainty in the situation, in which no ready-made rapid solutions exist. This is done by primarily focusing on (6) dialogicity in the meetings. The main aim is to generate a new joint language for experiences that do not yet have words and live in symptoms.

Open Dialogue is one of the most studied approaches to severe psychiatric crisis in Finland. Since 1988, there have been several studies of treatment outcome and qualitative studies analysing the development of the dialogue itself in the meeting (Haarakangas, 1997; Keränen, 1992; Seikkula, 1994; 2002; Seikkula *et al.*, 2003, 2006). Since this approach was institutionalized, the incidence of new cases of schizophrenia in Western Lapland has declined (Aaltonen *et al.*, 1997).

In a quasi-experimental study of first-episode psychotic patients, Western Lapland was part of a Finnish national API (Integrated

Treatment of Acute Psychosis) multicentre project conducted by the Universities of Jyväskylä and Turku together with STAKES (State Center for Development and Research in Social and Health Care) (Lehtinen *et al.*, 2000). The inclusion period for all non-affective psychotic patients (*DSM-III-R*) in the province was April 1992 through March 1997. As one of three research centres, Western Lapland had the task of starting treatment without beginning neuroleptic drugs. This was compared to three other research centres which used drugs in a standard way, most often at the very beginning of the treatment. In Western Lapland, 58 per cent of the patients were diagnosed with schizophrenia.

In the comparison of the patients with schizophrenia who participated in Open Dialogue versus those who had treatment as usual in another psychiatric unit in another province of Finland, the process of the treatment and the outcomes differed significantly. The Open Dialogue patients were hospitalized less frequently, and three of these patients required neuroleptic drugs, in contrast to 100 per cent of the patients in the comparison group. At the two-year follow-up, 82 per cent had no, or only mild non-visible psychotic symptoms compared to 50 per cent in the comparison group. Patients in the Western Lapland site had better employment status, with 23 per cent living on disability allowance compared to 57 per cent in the comparison group. Relapses occurred in 24 per cent of the Open Dialogue cases compared to 71 per cent in the comparison group (Seikkula *et al.*, 2003). A possible reason for these relatively good prognoses was the shortening of the duration of untreated psychosis (DUP) to 3.6 months in Western Lapland, where the network-centred system has emphasized immediate attention to acute disturbances before they become hardened into chronic conditions. DUP has been reported to vary between one to three years in a treatment-as-usual setting (Larsen *et al.*, 1998; Kalla *et al.*, 2002).

In a five-year follow-up with all psychotic patients the results had remained the same. In Table 1 the outcomes of open dialogues in Western Lapland are compared to a study revealing information of a treatment as usual in Stockholm, Sweden. What is surprising is that there actually exist few five-year follow-up studies on the whole. Comparing Western Lapland to a big city such as Stockholm includes problems of demographic differences between these two sites.

In the Svedberg *et al.* (2001) study in Stockholm, 54 per cent of participants were diagnosed with schizophrenia, which was about the same as in the ODAP group. In Stockholm, the mean age seemed to

TABLE 1 *Comparison of five-year follow-up studies of first-episode psychotic patients in Western Lapland and Stockholm*

	ODAP Western Lapland 1992–1997 N = 76	Stockholm* 1991–1992 N = 71
Diagnosis: Schizophrenia	59%	54%
Other non-affective psychosis	41%	46%
Mean age (years)		
female	26.5	30
male	27.5	29
Mean length of hospitalization (days)	31	110
Neuroleptics used	33%	93%
- ongoing	17%	75%
GAF at f-u	66	55
Disability allowance or sick leave	19%	62%

Note: *Svedberg *et al*. (2001).

be higher (30 years compared to 27 years in the ODAP group). This may indicate that in Stockholm the duration of untreated psychosis (DUP) was longer. The mean of hospitalization was 110 days with the Stockholm patients compared to thirty-one days with the ODAP group patients. Neuroleptic drugs were used in 93 per cent of cases in the Stockholm group compared to 33 per cent in the ODAP group. As an outcome, 62 per cent of the patients treated in Stockholm were living on a disability allowance compared to 14 per cent in the ODAP group.

Conclusions of the comparison need to be drawn with caution because we did not have any control of the differences of population in these two areas. The Stockholm results, however, are similar to other five-year follow-up studies conducted in a treatment-as-usual setting. For example, in a study in the Netherlands, Linszen *et al*. (2001) found that following an active psychosocial programme when patients had returned to treatment as usual, only 25 per cent managed without at least one relapse and their social functioning level was poor. Taking this into account, a suggestion may be made that Open Dialogue has given new promising aspects in the treatment of acute psychosis.

Concluding remarks

In this presentation I have aimed at describing the importance of focusing on the present moment in meeting with family and the social

network. Every conversational situation is lived in two simultaneous histories, namely in the one lived and in the one storied. Especially if we want to focus on generating dialogue as the primary form of psychotherapy, the importance of the polyphony of the voices becomes evident compared, for instance, to systemic family therapy that focuses on elements of family structure or family rules. In every form of psychotherapy dialogue is important, but often dialogue is regarded as a form of communication. That is one aspect of dialogue, but in this paper it is seen as the basic way of engaging with others actually and virtually in the way that forms the mind. Mind is not seen as an independent element of human psychological structure, but an ongoing process from one second to another between living persons. Dialogue is communication, but it is also the relation and process of forming oneself.

It is not a simple task to connect basic ideas of human life into a description of family therapy. What is common is the fact that in family therapy dialogue a multi-voice reality is constructed by the presence of more than one client and often more than one therapist. Polyphony of the voices becomes relevant in focusing on the dialogue itself, how to answer utterances in every present moment. Giving the example of the psychiatric system developed in the Finnish Western Lapland, the polyphony of voices and dialogism has become the basis of the practice. In systematic follow-ups the effectiveness of treatment of first-episode psychotic patients has been proved. This illustrates perhaps the fact that in dialogue own psychological resources of families are mobilized more than compared to systems that rely on the guidance of professional experts. In the studies this was seen when comparing open dialogues to treatment as usual.

Being involved in many projects for developing social network orientation, what is surprising is the often difficult process of learning to be in dialogue with our clients and our colleagues in the meetings. Perhaps as therapists we are so used to thinking so much about being skilful in methods and interventions that it is difficult to see the simplicity. All that is needed is to be present and to guarantee that each voice becomes heard.

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