

result of an active attempt of an embodied mind to cope with experiences that are so 'heavy' that it has been impossible to construct a rational spoken narrative about them. For example, most people diagnosed with psychosis have experienced physical or sexual abuse, either as a child or as an adult (Aas et al., 2019; Goodman et al., 1997).

Sometimes present-day stressful situations, that resemble earlier stressful/traumatic experiences in some respects, can evoke affects related to these earlier experiences. Affects, in general, can be seen as a bodily reaction, an attempt to recover the homeostasis that has been threatened by something that has occurred outside or inside the body. When dealing with huge affective arousal relating to past trauma, our embodied mind can generate hallucinations or delusions, instead of a clear narrative memory of these experiences. One could say that in psychotic behaviour the body talks through metaphor, 'narrating' and enacting the person's experiences. We need words in order to make sense of, and thereby cope with, intense affect/trauma, and in the absence of a clear narrative, psychotic experiences may appear. Some have called this the pre-narrative quality of psychotic experience (Holma and Aaltonen, 1997).

In therapeutic conversations it seems to be important to avoid identifying the traumatic experience as the reason for the psychosis, because psychotic experiences are not caused by the traumatic incidents alone, but rather are responses to *current* affective experiences which stem from the earlier experiences, as in the example below. Furthermore, psychotic phenomena can also be a response to biological changes, illicit drug use or organic brain damage.

To illustrate my main point, I would like to share the story of a woman who developed psychosis, fearing that her husband was under the influence of drugs and would come and kill her.² During the meeting with the family, it was discovered that 16 years earlier she had been living with a man who was a heavy drug abuser. While under the influence of drugs he had repeatedly beaten her, a fact that she had never disclosed to anyone else. A couple of months before her first psychotic episode, the man had phoned her for the first time in 16 years. On hearing his voice, she could not say anything, but her body shook, remembering the terror of dying that she had experienced while living with the threat of violence from him. The fear she felt towards her husband was a psychotic one; it was not him who was coming to kill her. At the same time, however, she was referring to something she had really experienced, that is, violence at the hands of her former partner. Such experiences of severe victimisation are not stored in the mind in such a way that they are recorded in language and can therefore be reflected upon (i.e. they are not stored in explicit memory), but instead remain 'locked' in the mind, which records errors in a timeless way in implicit memory (Van der Kolk and Fisher, 1995).

In the tradition of OD, a psychotherapeutic approach has been developed which is based on the idea of seeing hallucinations and delusions as a part of psychological functioning in crises, as being related to overwhelming affects.

PSYCHOSIS IS NOT AN ILLNESS BUT A RESPONSE TO EXTREME STRESS – DIALOGUE IS A CURE FOR IT!

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Introduction

This chapter describes how psychosis can be seen as an active psychological response to extreme/traumatic experiences, when it has not been possible to process the affects aroused by such experiences through language. If the Open Dialogue (OD) network manages to generate a deliberating atmosphere, allowing different, even contradictory, voices to be heard, including the voice of the person experiencing psychosis, then there is the possibility of constructing narratives of restitution and reparation, even many years after the psychosis first manifested. A number of key points about the practice of facilitating network meetings with someone experiencing psychosis and their network are highlighted.

Psychosis, the body, trauma and extreme stress

There are many ways of understanding psychotic problems. In the literature psychosis is mostly seen as a pathological state, which needs to be cured. However, the basis of the dialogical perspective on human life is to emphasise respecting the Other with his/her view of life, without conditions. Thus, it is important to see psychotic behaviour from the point of view of the unique life of the person at the centre of concern, without pathologising it. From the dialogical point of view psychotic experience can be seen as one way of dealing with terrifying experiences in one's life. Several authors have already contributed to the literature on the dialogical approach to understanding psychotic behaviour (Dilks, 2013; Lysaker and Lysaker, 2001; Seikkula et al., 2001).

In OD psychotic behaviour is not regarded as a distinct set of categorical phenomena, as in an illness. Instead such behaviour is seen to be the

In clinical practice it is unhelpful to see these as pathology in the sense of being a physical illness, rather than a psychological reaction. As a fruitful hypothesis for helping people in their psychotic crises, we could see hallucinations and delusions as one form of affect. Emotional states – such as feeling anxious, having panic attacks, or being in a depressed mood – belong to life as natural responses to different circumstances. When extreme, they can become problematic and prohibit or inhibit constructive responses to the stressors in our everyday lives. We may then be diagnosed as suffering from anxiety, or panic disorder, or depression. As I see it, these phenomena arise in a similar way to hallucinations and delusions, as hallucinations are also reactions of our embodied mind to extreme stress – usually there are several stressors at the same time.

By way of example, let's say a person hears the voice of a loved one who died suddenly. It is not difficult for this person to understand such an experience as their emotions trying to re-establish homeostasis and save him/her from the pain of loss. However, at some point, if the pain remains unbearable, this person may lose the capacity to understand in this way, i.e. to accept that the person is no longer alive and that there is therefore no voice coming from the external world. In psychotic experience an individual loses the understanding of how affective experiences relate to their lives. Hearing hallucinatory voices is not the criteria for the diagnosis of psychosis – rather it is not having the capability to test reality (Cullberg, 2000).

Bertram P. Karon carried out ground-breaking work in developing individual psychotherapy for people experiencing psychosis. In the book he wrote with Gary Vandembos (Karon and Vandembos, 1981) they show, using several case examples, how psychotic phenomena can be understood as a response to real and terrifying experiences. For instance, in one situation a young man started to speak Latin. Instead of seeing this as something random and meaningless, the therapist wondered if the young man had had an experience within the church. It transpired that he had been sexually abused by a priest when he was in the church choir. In psychotic problems, Karon and Vandembos see affective reactions as primary and only think about problems in reasoning and thinking as a secondary process. In their view people experiencing psychosis are living in a state of terror and because of that their reasoning may be affected. They think that psychotic behaviour serves as an active defence against something more terrible, death. In their reasoning, psychotic experiences relate to the terror of dying. Hallucinations and delusions are understood to be ways of dealing with the terrifying experiences in a non-direct, metaphorical way.

As a starting point for a successful therapeutic relationship, Karon and Vandembos (1981) propose that the psychotherapist should take a strong position by supporting the person they are working with in their defence against death, by promising not to let anyone harm them. And then, from a dialogical point of view, their descriptions of the link between psychotic experiences

and real-life incidents are very helpful in contributing to our understanding of the inner/vertical dialogues in psychotherapy (i.e. our relationship to past experiences). Unfortunately, they give a rather linear description about the role of the mother – and the family – as causing psychotic problems. In making this assumption, they were not able to collaborate with the family of the person experiencing psychosis, but instead proposed that the family should be met by someone outside the therapeutic process, and that the psychotherapist should not participate in these family sessions. In OD the family is not seen as pathological, as needing to be changed, but instead everyone is recognised and respected in the dialogue.

Generating dialogue is the response to psychotic experiences

In OD, the verbalisation of hallucinations or delusions is helpful in beginning the process of constructing a spoken narrative of prior terrifying experiences. The hope is that what was previously unbearable and unthinkable can become more bearable. A major aim in this process is to help the person experiencing psychosis to develop a fuller understanding of their reactions and to see how these are connected to their current and past experiences.

The role of the team in network meetings is to allow the person experiencing psychosis, and their network, to take the lead in determining the content of the meeting. The starting point for treatment is the language of the family – that is, how each family has, in their own language, named or understood the problem. The treatment team adapts its language according to the unique needs of the person experiencing psychosis and their family. Every conversation creates a new language (Bakhtin, 1984). Each person present speaks in their own voice and, as Anderson (1997) notes, listening becomes more important than the manner of interviewing.

When a professional first hears about someone's hallucinations or delusions, they may seem almost impossible to follow and understand. It is important, however, to accept hallucinations or delusions as one voice amongst others. In the beginning, these are not challenged, but the person is asked to say more about their experiences. The main task for team members is to ensure a response to the utterances of family members in a dialogical way, in order to promote new understandings among the different participants (Bakhtin, 1984). Team members can respond to what they have heard in a reflective discussion, while the family/network listen (as described in Chapter 1), and usually the family/network listen very carefully to what the professionals have to say about their situation.

Although it is not the case that every person experiencing psychosis has been a victim of physical or sexual abuse, this notion can help professionals to orientate more towards real events that have taken place, in their attempt to understand psychotic experiences through dialogue with the person's social network. And though our professional experience tells us that psychosis is

usually the consequence of extreme life experiences, in the OD approach there is no pre-planned agenda or assumption as to what these experiences might be for any given person. They could have been of any kind and could have happened at any time. Furthermore, the aim in the dialogue is not to find out the exact original experience(s), but rather to support discussions about many different issues, as these can open paths for healing. The important issue is for practitioners to take extremely seriously everything that people in crises are saying – especially ‘psychotic’ utterances – instead of seeing them as meaningless or impossible to understand.

As hallucinations and delusions often relate to real incidents from earlier in a person's life, it is important to take time to discuss them (see section below: ‘Some simple guidelines for dialogues with people having psychotic experiences’). For example, a team member could ask: “Did I hear you correctly when you said that you have control of your neighbour's thoughts? Could you tell me more about that?” The other network members could then be asked: “What do others think of this? How do you understand what M is saying?” The purpose of such questioning is to allow different voices to be heard concerning the themes under discussion, including the ‘psychotic’ voice(s). If the team manages to generate a deliberating atmosphere, allowing different, even contradictory, voices to be heard, the network has the possibility of constructing narratives of restitution or reparation (Stern et al., 1999). And, as Trimble (2000) puts it, “restoration of trust in soothing interpersonal emotional regulation makes it possible to allow others to affect us in dialogic relationships” (p. 15). To be open to each other's views and experiences is necessary for the person experiencing psychosis and the social network to begin to construct new words for their problems.

Once a young man asked for OD meetings.³ He and his family were very disappointed by the family meeting in a traditional psychiatric hospital that they had had when he had been hospitalised because of psychotic episodes. He said that his parents were willing to come to the meeting even though they had separated a long time ago and no longer had any contact with each other. He also informed us that his parents had had considerable difficulties in communicating with each other and that this was the reason they had separated. In the first meeting we met with the son, his younger brother and their mother, in the second with the two young men and their father, and in the third with all four family members together. The third meeting was loaded with extreme tension. The younger brother started by saying that this meeting should have taken place 20 years ago, and after a while the mother said the same. Difficult issues were taken up from family life when they had all been together in the past, such as the problems the parents had had in dealing with each other and taking care of the children when they were small. The father was very rigid in his attitude in the meeting, even in the way he was sitting, but he listened to the criticism from his children. When asked what he thought about their critical comments he

said that he felt bad and that it was not his intention to harm his children in any way.

Towards the end of the 90-minute meeting the atmosphere became more relaxed and the family even made some jokes about their history and laughed together. When asked at the end of the meeting how they had found the meeting, all of them said that they were surprised by how different it was to the meeting in the hospital. They said that in the hospital the doctor in charge of the meeting seemed to have the aim of finding out how mad the son was and how mad the entire family was. They felt very different in this meeting in the way everyone was heard and respected, even if they each had different opinions. This was the key difference from the other approach, a comment that they repeated at the end of the OD meetings that we had over a period of one and a half years.

Some simple guidelines for dialogues with people having psychotic experiences

In dialogical practice the main aim of the meeting is to generate dialogue, both between the participants and between their inner voices. This could involve, for example, pointing out that it is natural to have different thoughts about the issues that are being discussed – one does not need to have only one opinion. In this way the capacity to reflect is increased, which in turn makes it possible for those involved to hear more about how other family members have felt about the issues being discussed and to evaluate these different experiences and voices. Often there are surprises for family members – for example, parents may hear that their children experienced issues in their childhood very differently from the way that they did. In such a dialogue, family members may become more willing to share their own experiences and, if they are heard and taken seriously, to listen to other family members as well. This openness to other voices may lead to an increase in one's agency in life, as one comes to understand more about how one's own viewpoints relate to others.

In psychotic crises the task is the same as in other crisis situations, but there are some specific challenges to be aware of. The following four aspects are especially important in psychotic crises:

Having a relational focus throughout

This is the overarching basis of open dialogues. The relational focus is concerned with both horizontal (outer) and vertical (inner) dialogues.

In relation to *horizontal (outer) dialogues*, i.e. the communication between those who are present in the meeting, the main challenge is to cultivate dialogues in which all participants are equally respected and included. Practitioners should support network members to share information and opinions about

their lives, whilst at the same time listening and reflecting continually on what they are saying. This does not mean that everyone needs to speak an equal amount, as it is important that everyone is free to participate in the dialogue in their own unique way. In an acute crisis, the meeting is often started by listening carefully to the person experiencing psychosis, whilst at the same time being sensitive to the ways in which other family members react while listening to stories that may every now and then include psychotic utterances. When asking others to respond to such utterances, it is best to emphasise the affective experience of the person who was speaking, instead of getting into a debate as to whether psychotic experiences are 'real' or not. In this way the team can enhance connections between family members and reduce isolation. It is often extremely difficult for family members to accept the reality of the person speaking in a psychotic way. Practitioners can increase network members' acceptance of each other by genuinely respecting the experiences of every family member, including the person having psychotic experiences.

Another domain of the polyphony of voices are the *vertical (inner) dialogues* of every participant, and these should also be encouraged. Those experiencing psychosis do not only have 'psychotic' speech, but also communicate in more everyday ways about their life. Both forms of speech should be respected and listened to. Other family members are in a similar position of having multiple views/feelings. Even if they often feel frustrated and criticise the person experiencing psychosis, they always show care and concern about him/her as well. Furthermore, family members should be encouraged to speak about other aspects of their own life, not only those related to the crisis or the person experiencing psychosis.

Respecting the psychotic experience without conditions

As mentioned above, in optimal dialogues we do not challenge the life view of the other, but rather encourage the person to help us understand more about their way of seeing their life, whilst also listening to the way other participants in the meeting experience the same life issues. This is in marked contrast to the approach often used in psychiatric practice where staff are advised to support people experiencing psychosis to become 'reality orientated', by telling them that what they are saying is part of their psychotic experience (or often 'psychotic illness') and is not real. This kind of statement can be very unhelpful and damaging, especially in that it can lead to a separation and increasing distance between the person experiencing psychosis and professionals (Avdi, 2005). One of the basic elements of dialogical practice is to deepen the speaker's awareness and understanding of what they are saying, by taking this seriously. It is most unlikely that the person experiencing psychosis will be able to start to reflect on their own experiences, and to search for other not yet known aspects for which they do not yet have words, if their points of view are rejected from the very beginning.

Sometimes psychotic experiences and communication can take over a person's life, such that their more constructive voices become silenced, or are difficult to listen to. They may also have diminished agency in their capacity to communicate their experiences (Holma and Aaltonen, 1997, 1998; Lysaker et al., 2003; Roe and Davidson, 2005). In addition, I feel that a good deal of contemporary psychiatric discourse, and the practices associated with it, negatively affect the diagnosed person's agency, by stating that psychosis is a product of a brain disorder which has nothing to do with the life experiences of the subject. Comments such as these can limit the scope of the person's communication with others and thereby constrain possibilities for developing beneficial self-understanding and consequent helpful actions (Avdi, 2005; Harper, 1995; Holma and Aaltonen, 1998; Karatza and Avdi, 2011). When the reality of the person's experience is not accepted by the professionals who are present, this often results in the person feeling even less in control of their thoughts and feelings.

When someone starts to speak in a psychotic way in a network meeting it may mean that, at that very moment, they are beginning to refer to the most difficult/traumatic experiences in their biography, perhaps because these experiences have been 'touched upon' in the dialogue between those who are present. If we start to 'reality orientate' people at such moments, we increase the risk that it will not become possible for them to begin to expand on their ideas as to what has happened in their lives, including painful experiences. Therefore, it is important that team members instead focus on what is happening in the present moment. One can ask, for instance, "what did I say wrong, when you started to speak about that?", or "wait a moment, what were we discussing when M started to speak about how the voices have control over him?" The 'reason' for psychotic manifestations can often become apparent at such crucial points in the conversation.

By fully accepting the utterances of the other, we thereby encourage them to speak more about hallucinations or delusions. In acute crises most people having psychotic experiences think that their hallucinatory voices exist in a reality that is shared with others and it is especially important at this moment to encourage them to share more about their experience/beliefs by asking, e.g. "wait a moment, did I hear correctly when I heard you say that you think your husband is coming to kill you? Can you help us understand more about this? When did you start to think this? Do you think this way all the time or only some of the time?" These questions are examples of how we can include unusual experiences in everyday conversation, instead of defining such experiences as pathological or unacceptable.

It is not always easy to accept the other's psychotic utterances, especially in a time of crisis. It can be particularly difficult if a person, for example, wants to make contact with someone who he thinks is out to 'get him', or hears voices that prescribe the killing of a specific person. One way to proceed in this type of extreme situation is for the practitioner to comment on

the emotional part of the experience, by saying, for example, "it sounds like you are in considerable distress and we want to help you", but at the same time staff need to be careful to evaluate what the person could do in practice. In hearing hallucinatory voices that prescribe harm to oneself or to another person it is important to be clear with the person concerned that they must not do what the voice is saying, but instead invite them to start to reflect on their experience.

Later on, in the course of the recovery process, a person may come to think that the hallucinatory voices that they still hear do not exist in external reality, but rather are part of their inner experience, meaning that they are no longer psychotic (Cullberg, 2000). At this point the nature of our dialogue about the voices can be quite different than when the person was in an acute crisis. For example, one woman in psychotherapy started to realise that the voice of her aunt that she had been hearing was not coming from external reality, but actually gave expression to some fears that she had in relation to her aunt.⁴ In the course of therapy, we both came to think that the voices she was hearing may be related to the fact that her aunt did not always accept her religious orientation – thus the voices were no longer psychotic, as she could connect them to her life experience. She came to feel that she was no longer willing to carry on the debate with the voices about this issue.

Overall, regardless of whether we are working with someone in an acute crisis or at a later stage in the process, it is essential to have the attitude that our dialogues are with human beings and not with 'schizophrenic/psychotic patients'. If our attitude is that we are talking with a person with an illness, we can too easily become focused on searching for the pathological aspects of their experience, whereas the aim of dialogical practice is to mobilise the positive resources of both the person at the centre of concern and their family members.

Emphasising feelings and the affective aspects of the stories told

A person with psychotic experiences may share extreme stories that could scare both the professional team and family members. These can include auditory hallucinations in which there is a threatening voice commanding the person to do something violent or frightening visual hallucinations. Strong paranoid belief systems may also put professionals in challenging situations. A person having paranoid thoughts may insist on an answer from team members as to whether they share these beliefs. As mentioned above, getting into a debate as to whether experiences/beliefs are real or not is most unlikely to open ways into more dialogical deliberations about the person's life and the role of the belief in it, and one basic dialogical principle is to focus instead on the emotional aspects of the experiences that service users are sharing with us. In dialogues during psychotic crises, it may be especially important to focus on the emotional experience that the person is having

when they are telling us, for example, about the persecutors that are after them. This can be done in a simple way, for instance by saying "it sounds like you are in a situation in which you really feel very distressed", or "it really sounds like a scary situation for you. Could you tell me how you feel when you are being threatened?" These responses are only illustrative examples from situations in which I myself have participated. With questions such as these, I have found a way to a more open space in which it is possible to reflect about the person's life, including aspects unrelated to the threatening psychotic experiences.

A preference for being present in the here and now

This is one of the main overall guiding ideas in dialogical practice. Instead of focusing primarily on the content of the conversation, and on what is shared about what happened before the meeting, we concentrate more on what is said in the present moment, and how the responses to what is said affect the experience of the participants in the meeting. Any experiences that have taken place before the meeting can be discussed, but the emphasis is on the key emotions that are felt and expressed during the meeting.

In psychotic crises there are additional elements that emphasise the importance of this way of working. As mentioned above, whilst speaking about something that we as clinicians may think of as psychotic experience, the person concerned may, perhaps for the first time ever, be speaking – although with psychotic utterances – of the most extreme experiences in their life, for which they did not have words prior to this moment. It has been our experience that, in the initial contact with the network in crisis, there is a window of opportunity to discuss delusional thoughts, and the challenge for clinicians is how to be present in a way that supports further deliberation about these delusions. Our ability to do so depends greatly on the way in which we hear the stories that are shared and how we respond to them at these moments. In clinical practice, and from the studies I have conducted (Seikkula, 2002), I have learned to follow a guiding idea of stopping everything else in the dialogue and focusing on what has just been said at the moment that the 'psychotic' communication appears.

In addition to the above, we also need to be present to hear the first reflections that the person starts to have about the experiences they have had, as there could be long-lasting negative consequences for the treatment process if we are not. This became evident in a research study of crises where good and poor outcomes were compared. The research examined the first network meetings and the quality of the dialogue in them (Seikkula, 2002).

In the example below, the person experiencing psychosis (*P* in the transcription) was speaking about a situation at home which ended with him being violent towards his mother.⁵ At the end of his confusing story he started to reflect about his behaviour, but unfortunately the team did not respond to

this. Instead they tried to clarify what had happened at home when the violence occurred.

P: Well, it was last weekend; the police came to us. She [his mother] 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 around and said that it wasn't allowed to speak about 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 say that... 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 did she not say that the police came?

P: What?

T2: Why did she not say that the 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 those 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... You are only thinking of all kinds of futile things.

T2: And it all started last weekend, this situation?

T1: Yes

In the dialogue above, twice within a short space of time the team chose to focus on the part of P's story that referred to what happened at home when the conflict occurred and did not respond at all to his reflections about his violent act or his "strange thoughts". In both of those situations he was showing interest in his own behaviour in a healthy way and reflecting on this behaviour, but he did not receive any response from the team to help him develop his thoughts about this. In this specific process of care, it didn't become possible subsequently to discuss his psychotic thoughts, and indeed P rejected any offer of help. Not being present at critical moments, neglecting to respond to aspects of crucial topics, can lead to quite dramatic adverse outcomes.

Long-term psychotic experiences

During the period when I was working as a clinical psychologist at Keropudas hospital, I worked primarily on two wards for long-term service users, some of whom had been hospitalised for several decades. In most of these long-term situations we were successful in making contact with their family of origin

and arranging meetings with them, together with the service user. This contact, and the process of subsequent meetings, was a very thought-provoking experience for me in at least two respects.

Firstly, we were struck by the number of long-standing 'psychotic' stories that were shared in the meetings. Though initially we could not understand what these stories related to, gradually they started to reveal important meanings, in that they seemed to be related to real experiences in the family. For instance, one man spoke about how he saw blood running out of the eyes of someone and a cannon exploding in his stomach.⁶ In the very first meeting with his elderly mother it transpired that, when he was eight years old, he had been a witness to a truck accident in which his father exploded into pieces and died and, on that occasion, blood had really been running out of the eyes of his father. Another person would shoot anyone who came near him with his finger, saying that his fingers were cannons. In the meeting with his sister and cousins it transpired that his father had frequently engaged in shooting, in an attempt to banish children from his yard when they came to swim in a new lake formed by the building of a water-powered mill in the Kemi river. The construction work was a very painful process for the father, who had lost a lot of his farm because of the creation of the lake. It seemed to us that, when he felt threatened, the man repeated the gestures of his father, who had fired shots when he felt threatened in the past.

Secondly, we learnt that hospitalisation had often been a very traumatic experience for the entire family, and it had been even more traumatic because it hadn't been possible for family members to discuss and share their feelings about their relative being hospitalised. The emotional experience of feeling like a failure as parents or siblings, of feeling guilty about the problems of one family member, of feeling anger towards the treatment system that had not managed to cure their son or daughter – all these and other feelings had been stored as if they were unspoken 'deep-frozen' memories. Surprisingly, once we had made contact with the families, these strong emotions appeared very fresh and it was as if things had happened recently instead of, for example, 20 years ago when their son had been taken into hospital. Mothers, for instance, often wanted to have time to speak in detail about the period when their son started to have problems, and how this gradually led to hospitalisation. While speaking about these experiences from a long time ago, they usually became extremely emotional, crying a great deal, and often shared a feeling of having been powerless to do anything that could have helped their son or daughter. It seemed that families could only start to orientate to their present life and plans for the deinstitutionalisation of their son or daughter once they had had the opportunity to recount what had happened around the time of the first hospitalisation. This return to the community was successful on many occasions when we managed to gain good collaboration with family members, including the person who had been hospitalised long term.

Our experience has therefore shown us that, even after long-term hospitalisation, it is possible to engage in/resume dialogical work, work that can have a positive impact on the family and future plans.

Notes

- 1 This chapter is dedicated to the memory of my close friend John Shotter. Our plan was to write this chapter together and indeed the first outline was prepared together Sadly, John's illness progressed and he passed away in December 2016.
- 2 This example was first published in Seikkula et al. (2001).
- 3 This is a fictitious/composite example based on clinical experience.
- 4 This is a fictitious/composite example based on clinical experience.
- 5 This example was first published in Seikkula (2002).
- 6 This is a fictitious/composite example based on clinical experience.

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