THE KEY ELEMENTS OF DIALOGIC PRACTICE IN OPEN DIALOGUE: FIDELITY CRITERIA

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The intent of this document is to support the development of an Open Dialogue practice for whole teams participating in Open Dialogue meetings, for supervision and training purposes, and for helping in systematic research. These teams can also be used for "self-reflection" by an individual practitioner.

This work should be cited as follows:

Olson, M, Seikkula, J. & Ziedonis, D. (2014). The key elements of dialogic practice in Open Dialogue. The University of Massachusetts Medical School. Worcester, MA.

September 2, 2014
Version 1.1

Introduction

"Dialogic Practice" arose from "Open Dialogue" as an approach to help persons and their families feel heard, respected, and validated. Starting in 1984, at Keropudas Hospital in Tornio, Finland, staff already trained in family therapy decided to change the way inpatient admissions were handled. Following the work of Yrjö Alanen (1997), they altered their response to acute crises by having a network meeting, bringing together the person in distress, their family, other natural supports, and any professionals involved, in advance of any decision about hospitalization. This was the birth of a new, open practice that evolved—in tandem with continued clinical innovation, organizational change, and research--into what has come to be known as "Open Dialogue," first described as such in 1995 (Aaltonen Seikkula, & Lehtinen, 2011; Seikkula et al., 1995). The "openness" of Open Dialogue refers to the transparency of the therapy planning and decision-making processes, which take place while everyone is present. (It does not mean that families are forced to talk about issues therapists think they should be open about.) From the outset, this network approach was for all treatment situations. Over a ten-year period, this formerly traditional inpatient facility in Tornio was transformed into a comprehensive psychiatric system with continuity of care across community, outpatient, and inpatient settings.

The practice of Open Dialogue thus has two fundamental features: (1), a community-based, integrated treatment system that engages families and social networks from the very beginning of their seeking help; and (2), a "Dialogic Practice," or distinct form of therapeutic conversation within the "treatment meeting." This current document divides Dialogic Practice into twelve elements that describe the approach of the therapist(s) in the treatment meeting to the person, their network, and all the helpers.

The treatment meeting constitutes the key therapeutic context of Open Dialogue by unifying the professionals and the network into a collaborative enterprise. Thus, Dialogic Practice is embedded in a larger psychiatric service that shares its premises, because it is essential to have both aspects. The Open Dialogue approach is an integrative one in which other therapeutic modalities (Ziedonis, Fulwiler, Tonelli, 2014; Ziedonis et al, 2005; Ziedonis 2004) can be added, adapted to the needs of the person and family, as part of an unfolding and flexible "treatment web" (Hald, 2013; Seikkula & Arnkil 2014).

There are seven basic principles of Open Dialogue, which are the overarching guidelines that the Finnish team originally proposed (Seikkula et al., 1995). The principles are listed in the Table below:

TABLE 1: The Seven Principles of Open Dialogue
IMMEDIATE HELP
SOCIAL NETWORK PERSPECTIVE
FLEXIBILITY AND MOBILITY
RESPONSIBILITY
PSYCHOLOGICAL CONTINUITY
TOLERANCE OF UNCERTAINTY
DIALOGUE (& POLYPHONY)

Relevant both to Open Dialogue as a form of therapy and a system of care, these seven principles represent the broad set of values, on which the more finely focused twelve fidelity elements of Dialogic Practice are based. For the purposes of this discussion on Dialogic Practice, the two principles of "dialogue (polyphony)" and "tolerance of uncertainty" will be given special attention as the foundation of therapeutic conversation within the treatment meeting. The other five of the seven principles, which emphasize the organizational features of the system, will be explicated in another document on organizational change and the system fidelity characteristics (Ziedonis, Seikkula, & Olson, in preparation). This companion document on organizational change will describe different ways that the Open Dialogue principles and the treatment meeting have been integrated into clinical practice, treatment programs, agencies, and systems of care.

In the current document on Dialogic Practice, the seven basic principles of Open Dialogue are not all covered in full detail; however they are elaborated in other readily accessible source documents (Seikkula & Arnkil, 2006; Seikkula & Arnkil, 2014). The following discussion will focus on the twelve, key elements of fidelity to Dialogic Practice that characterize the therapeutic, interactive style of Open Dialogue in face-to-face encounters within the treatment meeting.

DIALOGIC PRACTICE: AN OVERVIEW

To be in a transformative dialogue with people requires presence, an attention to the living moment without a preconceived hypothesis or specific agenda. The art and skill of Dialogic Practice means that the therapists' communications are not formulaic. Open Dialogue involves being able to listen and adapt to the particular context and language of every exchange. For this reason, it is not possible here to make specific recommendations for sessions in advance, or for invariant phases in the treatment process. Prescribing this form of detailed structure could actually work against the process of Open Dialogue. It is the unique interaction among the unique group of participants engaging in an inevitably idiosyncratic therapeutic conversation that provides the possibilities for positive change.

At the same time, there are systematic elements of Dialogic Practice. In this way, there is a paradox. While every dialogue is unique, there are distinct elements, or conversational actions on the part of the therapists, that generate and promote the flow of dialogue and, in turn, help mobilize the resources of the person at the center of concern and the network. This is what we mean by the key elements. They will be defined and described below.

Dialogic Practice is based on a special kind of interaction, in which the basic feature is that each participant feels heard and responded to. With an emphasis on listening and responding, Open Dialogue fosters the co-existence of multiple, separate, and equally valid "voices," or points of view, within the treatment meeting. This multiplicity of voices within the network is what Bakhtin calls "polyphony." In the context of a tense and severe crisis, this process can be complex, requiring sensitivity in bringing forth the voices of those who are silent, less vocal, hesitant, bewildered, or difficult to understand. Within a "polyphonic conversation," there is space for each voice, thus reducing the gap between the so-called "sick" and "well." The collaborative exchange among all the different voices weaves new, more shared understandings to which everyone contributes an important thread. This results in a common experience which Bakhtin describes as "without rank."

As stated above, by calling a sequence "dialogical," we mean specifically that the sequence has the potential for a person to feel heard, which is the beginning of any change. Evaluating the dialogical quality of a conversation means, first and foremost, evaluating the responsiveness of the therapists. Among the first steps is often for one of the therapists to engage with the person at the center of the crisis in a careful, detailed, back-and-forth interchange. The purpose is to listen and, as necessary, assist in finding words for the person's distress,

otherwise embodied in symptoms, and evolve toward a common language. As illustrated below, having input from the network assists in shedding further light on the nature of the crisis. The dialogical therapist invites each person in the meeting to share their perspective and the various, related issues that come up during the conversation. Instead of looking at therapists' skills in terms of the way they conduct a structured interviewing methodology, the principal criterion is the often personal way the therapists respond to the afflicted person's utterances and those of others present in the meeting.

Responding and Reflecting

There are two fundamental skills required for clinicians to do Dialogic Practice: the skill of responding and the skill of reflecting (Rober, 2005). The skill of responding is a three-part process that applies to the way all the fidelity elements are employed. This process must be present to call an exchange dialogical. While defining the quality of the therapist's action, one has to look at the (1) client's initial utterance; (2) the therapist's response to that utterance; and (3) the response to the response given. How does the therapist's response further the experience of each participant in being heard, understood, and acknowledged? How do these three steps generate dialogically responsive interaction?

The other basic skill of Dialogic Practice—the skill of reflecting--is the ability to engage in an open, participatory, transparent, and jargon-free conversation with the network and other professionals in the meeting. The skill of reflecting builds on the skill of responding.

Parenthetically, "reflecting" is different than how this same term is used in other forms of therapy. For example, in motivational interviewing, "reflecting" refers to how the therapist actively listens to what the client says. In Dialogic Practice, this term refers instead to the way the professionals talk about their own ideas in front of the family. We have learned from others that this can be confusing since many therapists interested in Dialogic Practice have also been trained in motivational interviewing.

Monologue and Dialogue

The Open Dialogue treatment meeting includes both monological and dialogical communication. So-called "monological" sequences in dialogue are necessary to make practical agreements, or to gain new information that can assist in a more complete understanding of the situation. By monological communication, we mean there are sequences in which the therapists themselves introduce conversational topics. Such sequences can

comprise information gathering, providing advice, treatment planning, or otherwise initiating new subjects for discussion that did not build on what the client or another participant previously had said (Seikkula, 2002). In an Open Dialogue treatment meeting, up to one third (1/3) of the conversation can be monological, to stay consistent with the approach and conduct an effective meeting. Monologue can refer to the nature of communication either within the social network or that between the experts and the network.

That said, there is a difference between monological communication described above and what is meant by the term, "monological discourse." The latter refers to an institutional way of talking, in which there is a privileged, top-down expert without a contributing listener. Instead of sustaining a dialogue among the various participants, all of whom are regarded as legitimate and equal, an entirely monological approach works against a more collaborative process that can lead to new ideas and creativity. In explaining this contrast further, it is helpful to refer to John Shotter's (2004) translation of "dialogical" versus "monological" discourse into the more accessible terms of "withness thinking" versus "aboutness thinking" (Hoffman, 2007). In our clinical experience, this former way of thinking and practice has tended to open up more possibilities in psychiatric crises and to help unfreeze situations away from chronicity.

In what follows, we will describe each of the fidelity elements of Dialogic Practice in Open Dialogue and give clinical examples to illustrate them. The examples are drawn from the therapy sessions of the first and second authors, working together and separately. While every session incorporates these elements, we have chosen to include illustrations from different families. The reason for this is to give a sense of the different kinds of problems and situations we have addressed. There are also additional, supplemental definitions and examples of important concepts in the Glossary. These twelve fidelity elements are not separate but often overlap and occur simultaneously in actual practice.

Table 2: The Twelve Key Elements of Fidelity to Dialogic Practice in Open Dialogue
1.   **Two (or More) Therapists in the Team Meeting**
2.   **Participation of Family and Network**
3.   **Using Open-Ended Questions**
4.   **Responding To Clients' Utterances**
5.   **Emphasizing the Present Moment**
6.   **Eliciting Multiple Viewpoints**
7.   **Use of a Relational Focus in the Dialogue**
8.   **Responding to Problem Discourse or Behavior in a Matter-of-Fact Style and Attentive to Meanings**
9.   **Emphasizing the Clients' Own Words and Stories, Not Symptoms**
10. **Conversation Amongst Professionals (Reflections) in the Treatment Meetings**
11. **Being Transparent**
12. **Tolerating Uncertainty**

THE TWELVE KEY ELEMENTS OF FIDELITY TO DIALOGIC PRACTICE

1. Two (or More) Therapists

The Open Dialogue approach emphasizes the importance of multiple therapists meeting as a team with the social network. There should be at least two therapists in the meeting. The teamwork is essential to responding effectively to severe, acute crises and chronic psychiatric conditions. One therapist can be interviewing the client(s), while the other takes a listening and reflecting position. Or, it can be the case that both therapists are asking questions and engaging in reflections. The "reflecting process" of Tom Andersen (1991) and the "reflective

talk" of Seikkula & Arnkil (2006) are both acceptable formats and will be described in greater detail under Item #10 below. Further, it is important to differentiate Open Dialogue practice from elective, non-crisis-service, outpatient therapy. Over the past decade, Dialogic Practice has been adapted to more ordinary couple and family therapy (Olson, 2012; Seikkula, 2014), in which it is possible to conduct Dialogic Practice as a solo therapist. Of note, we are writing a summary of our experience on how to conduct Dialogic Practice as a solo therapist that we will reference here when completed.

2. Participation of Family and/or Network Members

The engagement with the network begins on the phone with the clinician asking the caller such questions as, for instance: "Who is concerned about the situation or who has been involved?" "Who could be of help and is able to participate in the first meeting?" "Who would be the best person to invite them, you or the treatment team?" These questions both facilitate network participation and help to organize the meeting in a nonhierarchical way, that is, with input from the client(s).

By valuing the inclusion of the family and other members of the social network from the very beginning, they typically become important partners in the treatment process throughout.   At the same time, there is flexibility based on the willingness of the person at the center to have their relatives present. The team can meet separately with different family and network members when conjoint meetings are not possible, as in many instances of violence and abuse.

As we will describe below (under Element #6), meetings without family or network members involved can also occur in which the therapist will then ask questions inviting the person to comment on what they think an absent member would say if they were present.

3. Use of Open-Ended Questions

The actual treatment meeting itself begins with open-ended questions asked by the clinicians. After introductions, an opening thus could be formulated by simply asking, "Who would like to start?" Or, "what would be best way to begin?" Once this kind of collaborative process becomes established and expected, it is naturally carried forward into subsequent meetings as a taken-for-granted element. In the very first appointment, it is important to emphasize the two questions that routinely commence an Open Dialogue meeting and were proposed by

Tom Andersen (1991).   They are: (1) "what is the history of the idea of coming here today?" And, (2) "how would you like to use this meeting?"

In this way, there are three subcategories of open-ended questions that we would like to address. First, there is the use of the "two questions" in the very first meeting; second, there is the use of the second of those questions in every meeting, and third, the ongoing practice of open-ended questions throughout the treatment process.

A. The History of the Idea to Have the Meeting?

"What is the history of the idea of the meeting? This question usually occurs only in the initial meeting and comes at the beginning. But, depending on the nature of the intake, it can also come later in the first meeting. It can be phrased in various ways and is addressed initially to the whole assembly, not just one person. "How did you have the idea to have this meeting?" Alternately, it is possible to start by asking, "Who first thought of having this meeting?" There is also a range of possible follow-up questions meant to engage everyone present: "How did others learn about this idea? What did you think of coming here today? Who agreed the most and least with the idea of contacting the team? What would you like to accomplish?

It is important to give everyone a chance to discuss their ideas about the meeting. At the same time, if, at any time, someone does not wish to speak, it is equally important not to force them to do so.

This type of question invites people to speak in a reflective voice. By reflective, we mean asking people to discuss their own purposes, intentions, and aims with regard to the decision of seeking help. Beginning in this way, this first question addresses the immediate context and is neutral toward any definition of a problem or symptom. It encourages people to describe the situation leading up to the meeting and the important people involved. Despite the emphasis on history, the question gives immediate multiple entrees into the present moment. Andersen (1991) writes, "The idea behind this question is to reach an understanding about how much those who are present are committed to the idea of being present (p. 159)." Often when asked, different participants express different viewpoints on their commitments to being present, which is important to know, especially when the idea of therapy itself may be contested terrain. At other times, this question can locate a potential resource by identifying people not present who could be helpful. This question does not have just one meaning or effect, and sometimes something completely unexpected happens.

B. How Would You Like To Use this Meeting?

The second question is "How would you like to use this meeting?" The question can be phrased in different ways. As with the earlier question, the second question is addressed to the whole assembly, not to one person. At the same time, it is important to give everyone a chance to respond to this question.

This second question is asked in the first meeting and, with some variation, in all subsequent meetings. Usually this question occurs at the beginning of a meeting. There are instances where it comes later, so the timing depends on the therapist being sensitive to the particular nuances of how a particular meeting is unfolding.

The rationale behind this question is that in Dialogic Practice, it is the clients rather than the professionals, who principally determine the content of the meeting, That is, we talk about what the clients want to talk about. For this reason, in every meeting, the therapist asks the client how they wish to use the meeting. Over time, with such repetition, the second question may become more implied, rather than directly stated.

Case Example of the Two Questions: The L. Family

The L. Family consisted of David, age 59, a paralegal, his wife, Tracy, age 56, an occupational therapist, and their son, Jack, age 30, who rarely spoke and lived with his parents. Jack was hospitalized for depression for the first time when he was 16 years old. He has had multiple diagnoses over the years (psychosis NOS, schizoaffective disorder, and schizophrenia) and had been involved with mental health services until several years ago. The first Open Dialogue meeting with this family began with the two therapists and the parents sitting together in a circle, while Jack chose to sit in a chair slightly outside the arrangement, listening, seeming occasionally to be communicating with invisible presences. There were pleasantries exchanged at the beginning and one of the therapists' then started, signaling the beginning of the therapeutic conversation:

Therapist 1: "So, here we are. Should we start?"

Therapist 2: "Yes, let's start."

The therapists introduced themselves to Jack and asked the parents if they minded being called by their first names. Therapist 1 said, "Jack, do you prefer to stay where you are, listening?" His mother suggested to Jack to join them, but Therapist 1 indicated that he did not mind if Jack stayed where he was, if that is where he felt most comfortable. Therapist 1 then asked the first question:

Therapist 1: So there is a history behind this meeting? Was it the case that you wrote to me? Or, how was this? Someone wrote....

David: I wrote...

Therapist 1: So you wrote to me. Ok.

David: I wrote to both of you (looking at Therapist 2). I got email addresses from your universities. Actually Tracy dictated the first letter. It was a mutual decision.

Tracy: I told him to polish it up...

David: I didn't expect a direct answer.

Therapist: Yeah.   You didn't expect a direct answer.

The father then described how he had been searching on the web for an alternative to the kind of psychiatric care that his son had dropped out of some years before. There were long descriptions of their negative experiences with professionals. Jack became restless and started to leave the room.

Therapist 1 (addressing Jack who is standing at the door): When did you hear about coming here for the first time?

The therapist asked this question several ways, and the parents repeated the question until Jack answered: "Three days ago."

A few minutes later, the therapist asked the second question:

Therapist 1 (looking at Tracy): How do you think it is best to use this time here now?

Tracy: It is hard for us to know what is the best to do for Jack? That is what we are thinking about mainly now. That is why we think this kind of psych treatment would be better. That it might open him up more to the ......(search for the word.)

Therapist 2: to the community? (A word Tracy had used earlier.)

Tracy. Yes, thank you, the community.

These two questions let the therapists know that the parents both were committed to the idea of doing Open Dialogue, rather than in conflict about it, and had a shared motivation to help their son. There was evidence that Jack was not opposed to the idea, since he willingly came with them. These questions created a window on the parents' joint perception that there was "more to Jack," whom, as they explained, had been defined as chronic and hopeless by the

mental health system. This excerpt also provides an illustration of making contact with each person early in the meeting and allowing each person to have a voice in relation to the theme being discussed, namely, the nature of the meeting.

After beginning with above-mentioned questions, it is important throughout the meeting to have in mind formulating the questions in an open-ended way, so that clients can take the initiative both to speak about what they see as important and in the way that they would like to discuss it. For therapists, this means that they guide the dialogical process by neither determining nor selecting topics, but by their way of responding to clients' utterances. In the next section, and throughout this document, there will be examples of this kind of open-ended inquiry.

4. Responding To Clients' Utterances

The therapist promotes dialogue by responding to the client's utterances commonly in three ways that invite a further response. This includes (A) using the client's own words; (B) engaging in responsive listening; and (C) sustaining attunement to nonverbal utterances, including silences.

A. Use of the Client's Words

The clinician actively follows what the client says and integrates the client's very same words and phrases into their responses. The above example shows how the therapists do this, closely listening to what clients say and repeating the client's own words in asking questions or making other comments. What the client has previously said is incorporated—with their very same words-- into the therapists' responses. Here is a brief vignette from the L. family of David, Tracy, and Jack that took place in the initial meeting described above.

Case Example of the Use of Clients' Words: The L. Family

David: I didn't expect a direct answer.

Therapist: Yeah. You didn't expect a direct answer.

David: I didn't expect an answer. I knew there was a training program in Open Dialogue. I didn't think it would be a direct possibility. I thought maybe, you'd say at a future point. I was surprised. It made me think that I was on the right track.

B. Responsive Listening To Make Space for Stories That Are Not Yet Told

The practice of repeating words leads naturally into "responsive listening," or listening without a specific agenda. Responsive listening often creates an atmosphere in which the clients' begin to tell important personal stories that they have not shared--or do not share easily--with others, especially professionals. There is evidence that the therapist's responses are effective when, for instance, there is change experienced during a meeting in the direction of a calmer atmosphere. The conversation has pauses, silences, and more shared exploration of--reflection about—issues and concerns in a dialogical ebb and flow.

In the meeting with the L. family of David, Tracy, and Jack, the therapists listened responsively. They repeated words, or, with small questions, invited alternate and more hopeful perspectives (together with a lot of "Mhms"). In response, the parents expanded on the qualities of their son that gave them hope. They told several pivotal and unexpected stories that the therapists never could have anticipated. For example, his parents described how Jack saved a woman's life in the residential community he was living in by notifying staff that she was suicidal. This and other affirming stories told during the session characterized Jack as a person capable of acting to help and protect others, rather than only as a person in need of help and protection himself. As these stories were told and heard by the Open Dialogue clinicians, a more positive identity was constituted and new possibilities were reviewed for Jack's recovery that had not been captured by his diagnoses.

C. Nonverbal Attunement, Including to Silences

The therapist shows attunement to the client's analogic (nonverbal) communications. Importantly, this also includes allowing for and tolerating silences in the conversation.

It is crucial to pay close attention to what is being communicated through body-based channels as well as words. Here is an example from the above meeting when the therapist returns at a later point in the meeting to address his initial encounter with Jack:

Case Example of Responding to a Body-Based Communication: the L. family:

Therapist 1 (addressing Jack): When I first met you in the reception, and I proposed to shake hands, you said, "No, I don't shake hands…" Can you help me a bit more: Why don't you shake hands?

Jack: I didn't feel like touching you.

Therapist 1: Oh, you didn't want to touch.

Jack: No.

In the above example, this exchange elicited from Jack a clearly verbalized preference, in contrast to expressing his voice in the meeting principally through physical gestures such as sitting outside the circle or leaving the room when sensitive issues came up. At the same time, while such analogic (nonverbal) behaviors might be viewed as symptoms, they are respected as important communications within the meeting.

In this way, therapists notice clients' gestures and movements, their breathing, change in their tone of voice, their vocal pitch, their facial expressions, and the rhythm of their utterances and changes in that rhythm. If a therapist's question produces a pause in the client's breathing, this is meaningful. It may be a sign that the question was too difficult or challenging and thus blocking the possibility of new meanings arising.

Allowing for silences in the therapeutic conversation can be another important form of therapeutic attunement, since silence often offers a creative prelude for untold stories and the emergence of new voices. The allowable period of silence cannot be quantified, but has to be felt from within the shared context. Such indices are essential for the therapists to notice and know how to respond to, with the hope of understanding as much as possible the meaning of what the client utters.

5. Emphasizing the Present Moment

The clinician emphasizes the present moment of meeting. There are two, interrelated parts to this: (A) responding to the immediate reactions that occur in the conversation; and (B) allowing for the emotions that arise.

A. Responding to Immediate Reactions

This means a preference for responding to the client's immediate reactions that occur in the here-and-now therapeutic interaction, rather than on their reports on what has happened outside the therapy room. A simple example of this in the meeting described above with Jack and his family is the interchange about shaking hands.

B. Allowing Emotions to Arise

A more complex dimension of emphasizing the present moment unfolds if the client becomes emotionally moved while speaking about a sensitive issue. When emotions arise such as sadness, anger, or joy, the task of therapists is to make space for their emotions in a safe way, but not to give an immediate interpretation of such emotional, embodied reactions. Here is an example of the latter:

The V. Couple: Emphasizing the Present Moment When Emotions Are Present

Margaret was a 25 year-old woman who has been on disability for depression. She and her husband Henry were coming to their second session of couple therapy. The first session had focused on Margaret's symptom of severe depression.   The beginning of the second session seemed rather chaotic and tense. Therapist 1 recalled the way Margaret and Henry, who were about 5 minutes late, entered the building. It seemed that there was some commotion, and Henry had to convince Margaret, who appeared quite upset and agitated, to come into the office. The therapist asked Henry how he was doing. "Quite good," he answered. The therapist turned to his wife:

   T1: "Margaret, what about you?"

   M: "Well, I feel differently. I did not want to come here today. I am not usually like this…"

   T1: You didn't want to come here today. For some specific reason or?

   M: I think that I have just been working too much, and I am tired.

   T1: Mhm.

Margaret's answer seemed to contain three disconnected statements. The therapist's answer--"you didn't want to come here today?"--was a response to one of Margareta's utterances and not the other two. It did not comment on her display of emotion, yet addressed the specific concern most active in the present moment, "not wanting to come," which is an invitation to be in dialogue.

6. Eliciting Multiple Viewpoints: Polyphony

Open Dialogue does not strive for a consensus, but for the juxtaposition and creative exchange of multiple viewpoints and voices, even if they are in tension between people or within a person. There are two dimensions to the multiplicity of viewpoints and voices, or polyphony: (A) outer and (B) inner. In outer polyphony, the therapist engages everyone in the

conversation, encouraging all voices to be heard and respected, while, integrating incongruent language, and managing a dialogue instead of a monologue. In inner polyphony, the therapist listens for and encourages each person to speak about their own point of view and experiences in complex ways.

A. Outer Polyphony

Everyone should be listened to and given the possibility of speaking, not just the person identified as having problems or symptoms. Experiencing, or "living in," the polyphony of voices within the meeting, a multiplicity of voices, the clinician should be sensitive to everyone present and hear from everyone about the important themes under discussion. In both the first example of the L. family of David, Tracy, and Jack and the second example of the couple, Margaret and Henry, the therapists made sure that each person was given the chance to speak. With Jack's family, there was an interweaving of their different voices into a common understanding of their collective isolation, not just focusing on Jack's predicament. Here is a further example from the therapy of Margaret and Henry.

Case Example of Outer Polyphony: the V. Couple

In the second session, Margaret and Henry progressed from a state of turmoil and escalating conflict to the emergence of a more constructive interaction that culminated in their open discussion of their differences. As we described, Margaret began the session in an upset, agitated state. She stated early in the session that her husband was never home. The therapist responded by repeating her word with an edge in his tone of voice and directness that matched her emotional intensity: "What does "never" mean?" After this comment, there was a palpable shift. Instead of continuing to display an escalating sense of misery, Margaret began to speak more respectfully to the therapist, as if she suddenly felt the session might hold the possibility of her being heard. Henry also changed after the therapists' comment and began to express himself more clearly in an assertive voice that dissented from that of his wife. Prior to this exchange, Henry's comments were almost incoherent. As the therapist continued to engage with each partner in a responsive way, there emerged a dialogue not only between the therapist and each partner, but also between the couple themselves. They, for the first time, started to speak from distinct "I" positions, addressing their partner as "you." They were each able to maintain the clarity of their own separate perspectives and listen to and hear the other person's perspective. While not initially agreeing, they, nevertheless, began to negotiate toward eventually forging a new solution to their central conflict. In this way, a small segment of a conversation reconstituted an entire context as a dialogic one that sustained polyphony.

Another key dimension of the principle of polyphony is the clinician's ability to integrate language by other professionals and members of the social network that is jarringly incongruent with the dialogical way of working.   The occurrence of such incongruent comments does not occur in every session, but handling such remarks is such an important element of sustaining a polyphonic conversation that we are including it here. Here is an example from a third family, the P. Family.

Case Example: Integrating Incongruent Remarks: the P. Family

The P. Family was seeking help for their 25 year-old son Christopher who had had an acute psychotic episode several years ago while in his last year of college. His parents, John, age 60, and Sheila, age 56, who had been going through a difficult divorce when Christopher had this crisis, had remained embattled and estranged. Sheila was a teacher with a stable job, while John was an unemployed carpenter.   During Christopher's psychosis, his parents had him involuntarily hospitalized at a private university hospital where his treatment was primarily psychopharmacological. He had had trouble holding a job since then and was living at home with his mother, Sheila. Christopher had remained resentful and angry about the hospital commitment and the treatment he received there.

At one network meeting, the family's longtime primary care physician attended for the first time. He had remained both John's (the father's) doctor and his trusted ally, while Sheila and Christopher no longer saw him as their doctor.   Sheila, John, and Christopher were all present at this meeting.   The doctor said abruptly and immediately at the beginning: "There are three things required in a situation like this: medication, cognitive-behavioral therapy, and family therapy." Christopher suddenly became flushed, hunching his shoulders and looking distressed. The Open Dialogue clinician knew that this young man had had an extremely negative experience with medication while in the hospital and felt he was doing better without taking them. At the same time, his parents were in tense disagreement about the issue of medication. The clinician responded to the doctor by saying: "Can you tell me a little more about how you reached this conclusion?"   The doctor paused and reflected.   He then addressed the son, seeming to sense his discomfort: "I am sorry; I think I made a mistake by starting with these three things."   Later in the meeting, the therapist returned to the ideas of an individual cognitive-behavioral therapist and medication and discussed these recommendations with everyone's participation.

The reason the doctor's recommendations were incompatible with a dialogical approach is that he began the meeting from a monological position of top-down expertise that generated discomfort, rather than one of collaborative listening that allowed everyone to have a voice.

B. Engage the Multiple Inner Polyphony, or Voices, of the Client

The therapist listens and engages the multiple views and voices of the client. These may be possibly conflicting viewpoints or voices expressed by the same person. The above example of the primary care physician is actually also an example of accessing an "inner polyphony." At first, the doctor spoke in his professional role as a knowledgeable expert, in which he inadvertently produced a breach of empathy with Christopher. He then repaired the breach by expressing his sensitivity to Christopher's discomfort. In this way, the doctor himself spoke in more than one voice: first, as an expert using general knowledge, and second, as an empathetic clinician responding to the present interaction. This kind of movement is key to Dialogic Practice.

While interviewing clients, dialogical therapists ask about absent members. This is another way to evoke the expression of inner polyphony. A usual question is: "If X had been here, what would they have said about the issues discussed?" This is an example of a hypothetical question. The idea of such a question is for the client(s) to imagine a conversation with an important and relevant person in their life who could not be present in the meeting. In this way, the voices of important others becomes part of the outer conversation, and the client's inner dialogue becomes subject to new examination and reflection. At times, the question itself provokes a spontaneous shift in a dilemma posed by a client in relation to an absent other. A powerful example, which comes from the L. family, occurred not in the first meeting but later on in the treatment process.

Case Example of Engaging Absent Members: the L. Family: Inner Polyphony and Engaging Absent Members as Voices in the Inner Dialogue

This example comes from the L. family described earlier: David, Tracy, and their son, 32-year-old Jack. During the course of treatment, Tracy died suddenly. David was grieving and despondent. At the time of his deepest grief, he once questioned whether Tracy might still be alive, if he had attended more to getting medical care for her, rather than focusing so much on getting this new form of mental health treatment for Jack.

In a meeting, Therapist 2 asked: "If Tracy were here now, what would she say about the decision to devote your efforts to getting help for Jack?" David thought about it, and said that Tracy was happy that they had spent the last year of her life going to these meetings as a family. She told David that her oncologist had said that it was likely she had actually lived longer to ensure that Jack was in a better place before she left the world. Jack was present when David spoke about Tracy's perception that Jack

had been improving, had a future, and had likely helped to prolong Tracy's life instead of hastening her death.

7: Creating a Relational Focus in the Dialogue

While interviewing clients, dialogical therapists are interested in working with the themes and issues within a relational frame. For instance, when a family member is angry and critical toward a professional, it is not framed as manifestation of a "personality disorder," but as their response to an actual relationship and specific interaction with that professional, thus making their anger one voice within a polyphonic conversation.

Relational questions are an offshoot of this relational way of thinking and are asked in order to bring greater clarity to the situation. This can be achieved by, for example, asking questions that address more than one person, define the relationships in the family, and express an interest in the relational context of the problem or symptom. In the meeting with Jack's family previously discussed, one of the therapists asked Jack's parents to define what percentage of the time they spent caring for Jack as opposed to focusing on their own relationship and their own lives. This question is relational in the sense that it draws several participants into a discussion in which relationships can become more clearly defined and differentiated, instead of more confused.

In Open Dialogue, there are many variations of relationally oriented questions that draw on systemic, solution-focused, narrative, and psychodynamic styles of inquiry. For instance, we can ask the kind of so-called "circular" questions that were first invented by the Milan systemic team (Boscolo, Ceechin, Hoffman, & Penn, 1987). Such questions highlight a difference or address relationships in the family. (For a more in-depth discussion of circular questions, please see the Chapter X: Open Dialogue and Family Therapy).

In Open Dialogue, we do not ask these or any questions as part of a structured interviewing methodology or a preplanned sequence of questions that will lead toward crafting an intervention. Such structured methods tend to constitute monological sequences, rather than dialogically structured interactions. Instead, in Dialogic Practice, questions are put forward as responses that it is hoped, resonate with the unique opportunities within the conversation, thus used in a creative, improvisational, and sparing way to open up new pathways for voice and expression. We have coined the term "relational questioning" to signify this kind of dialogical inquiry.

Case Example of Using a Circular Question: the H. Family.

An example of the use of a circular question comes from a different family consisting of two parents, Mike, a business executive, and Anna, a consultant with two children: 18-year-old Carla, and 16 year-old Joe. Carla was hospitalized after she confided to her brother that a cricket was telling her to jump off the 3rd floor porch outside her bedroom. The psychiatrist at the hospital told the family that their daughter had a chemical imbalance in her brain. She was treated with high levels of medication. The medication eradicated her "psychotic" voice, and Carla has continued to be under the care of an outpatient psychiatrist.   The maternal grandfather thought the family should also pursue Open Dialogue therapy.

In this example, the therapists were meeting with the family for the second time. The father began by bringing up the idea of a "chemical imbalance" and seemed to be greatly irritated by having to participate in family meetings, especially ones that seemed to be about "process" instead of "concrete steps." After listening and acknowledging the father's point of view, the therapist asked the family a difference, or circular, question about agreement versus disagreement, "Who else in the family agrees with Father about the family meetings?" Joe said, "Well, there are other things I could be doing." Carla answered that she agreed that she had a chemical imbalance and needed the medication, but thought the first family meeting made her "feel less isolated." The mother answered,

> "I disagree with Mike. I think that when I think about all four of us together, I can understand why Carla hears voices. I think her voices are a product of all of us together ... I can't really explain it, but I think we need to meet as a family and discuss whatever issues come up. There are a lot of things that we do not talk about, that we should talk about, not only to help Carla, but all of us. Yes, that is what I really think."

Carla, who was sitting next to her mother, took her hand, linked her fingers inside her mothers,' and exchanged a smile. In this way, the question about the meeting itself allowed the mother's voice to be heard in a family where the father's perspective, aligned with the dominant psychiatric discourse, had become too important. The relationship between the parents became more clearly defined when the conflict between them became openly stated.   In part because of this conversation, a treatment team was formed in which a new psychiatrist regularly joined the family meetings together with the Open Dialogue therapists.   The family made good progress with this arrangement, especially Carla, who began to recover. She returned to school and began tapering off her regimen of psychotropic medications. After approximately 18 months of meetings in this configuration, Carla's parents asked to do couple therapy instead. Carla continued seeing an individual therapist, while moving forward with her own life, having her first boyfriend and returning to school.

8. Responding to Problem Discourse or Behavior as Meaningful

There is an emphasis in Dialogic Practice on "normalizing discourse" in contrast to speaking about issues as pathological, which often is where things start. The therapist listens for the meaningful and "logical" aspects of each person's response. What this means in practice is that the therapist strives to comment and respond to what was said in a way that sees symptoms or problem behavior as making sense, or "natural" responses to a difficult situation. This shift to normalizing discourse affirms people by emphasizing how problem behavior is meaningful within a particular context, rather than how it is "wrong" or "crazy." Normalizing talk has an affinity with the Milan systemic therapy technique of "positive or logical connotation," although the latter technique is given as an intervention in the form of an explanation to the family. "Normalizing talk" is a much more subtle process of understanding and responding woven into the conversational back-and-forth exchange. It also can occur by means of locating unique outcomes, or exceptions, in "problem-saturated stories" (Olson, 2006; White, 2007). (Please also see Chapter X that compares Open Dialogue and family therapy and further describes the differences between normalizing talk and family therapy interventions such as "reframing" and "positive or logical connotation.").

For instance, in the earlier excerpts of the L. family and the V. couple, a normalized discourse replaced a pathological one in the collaborative emergence of meaning. The very first session described above allowed a discourse to evolve that embedded the experience of Jack and his family in a history of isolation and estrangement from their families of origin, a normalized context in which their experience became more understandable. Similarly, in the session with Margaret and Henry, Margaret's symptoms became connected through the discourse to the normalized context of a young couple being "between two families," with a particular focus on the loyalty bind of the husband in relation to his mother.

9. Emphasizing the Clients' Own Words and Stories - Not Symptoms

Dialogic Practice invites the telling of what has happened in a person's life, their experiences, thoughts, and feelings, instead of reporting on symptoms. Telling stories may happen easily or may require a more deliberate search for language. Openings in the form of one word or sub-sentences may be key words with highly relevant associations to the problem situation. The therapist zeroes in on these words that can give access to a narrative of a person's suffering. This is part of a larger process of evolving a common language, and larger story.

In this way, severe symptoms may be understood as embodying inexpressible or unspeakable dilemmas. They are often rooted in terrible, often traumatic, experiences that resist ordinary language and the ordinary capacity to express experience in narrative terms. For instance, hallucinations may be signs of such otherwise inexpressible experiences. The person who exhibits the most severe symptoms may also have the least access to language. More time may be devoted to exchanges with the most acutely symptomatic person whose voice may be the most incoherent, and thus, the weakest. Further, in meetings that take place during crises, the most difficult, and consequently the most important, issues are often indicated by a single, key word a person says, rather than expressed as a full story. This type of one-word utterance that may sound strange, may be repeated and turned over, slightly altered by the therapist until a more mutual wording evolves. The aim is to arrive at shared understandings that give voice to the person's experience, making it more understandable and thus, fostering new possibilities for everyone. This often means focusing on the small details of the person's description of what happened, or what actually happens in the room while the person is telling their story.

Case Example of Emphasizing Stories, not Symptoms; the P. Family

This example comes from the work with 25-year-old Christopher. We described this treatment earlier in relation to the network meeting with the family doctor. Christopher had suffered an ongoing crisis for three years. The therapists were meeting with his parents, John and Sheila, who were divorced, and Christopher, who had a psychotic episode in college from which he had not fully recovered. He had had trouble functioning since that time and had been living with his mother. Therapist 1 was joining this therapy as a consultant.

Therapist 1: So…. Where should we start? (Looking toward Christopher) I understand that this is not your first meeting, but perhaps you can say something for us. How do you understand what this is all about?

Christopher: Sure. Well, for about five years, five years ago, I have felt sort of muddled in my head, um, just had thought that it was depression, um but, sort of um, had trouble focusing, after I came back from a semester abroad in (a foreign country), I was doing fine for my whole life, you know, before that, um, then I went to my junior year abroad, fall semester junior year, fall semester, of college, I am twenty-five, yeah, and I was in college for four years, um, after I came back I started having trouble, some depression, just trouble focusing in class, and just was unhappy generally, with my mental state, um, a lot of thoughts going around, the best way I describe it was like, fuzzy, fuzzy thinking, so um, like, um, that has been going on for the past five years, so um, yeah um…

Therapist 1: – You said that you were "unhappy"?

Christopher: Yes, unhappy….

The therapist asked each of the parents how they understood the situation. They each had different perspectives. (This is also an example of outer polyphony.) Mother described how she lived with Christopher and observed his "fear" of life. Her understanding was that the "code of silence" in their family when Christopher was growing up had caused the current situation. By "code of silence," she meant that the problems in the family were rarely openly discussed. Father disagreed and said instead that the problems Christopher had stemmed from his childhood difficulties, including a longstanding problem with not being able to interpret "social communication." Christopher challenged his father's point of view. The therapist then returned to Christopher and asked him to say more about how he understood his own situation. Christopher answered, "heartbrokenness." "Heartbrokenness" was Christopher's word. The therapist repeated the word. The therapist's response invited Christopher to tell the story of having fallen in love with a girl while on a semester abroad and having had to leave her to return to the US. He thought this experience was the basis of everything else that had happened so that he had become, to use his mother's word, "paralyzed" in life. The separate voices and viewpoints of each of the family participants remained polyphonically distinct in the discussion, nor was there one perspective that the therapists explicitly privileged over another. That said, the therapists nevertheless spent a great deal of the session helping Christopher to expand the story of his "heartbrokenness."

10. Conversation Among Professionals in the Treatment Meeting: The reflecting process, making treatment decisions, and asking for feedback

In every meeting, the professionals' conversation with each other should be emphasized. When doing so, they are advised to look at and talk to each other and not at the family or any other participant.

There are three parts to having a conversation in front of the family. The first two are interchangeable; but the third one always comes after the professionals' dialogue. First, there is the reflecting process, in which the therapists engage in reflections that center upon their own ideas/images/associations, with the client and family present. Second, the therapists converse with the other professionals during the meeting on planning the treatment, analyzing the problem, and openly discussing the recommendations for medication and hospitalization. And, third, the family comments on the professionals' talk. That is, after the reflections, one of the therapists invites the family and other network members for their responses to what they heard.

A. & B. Reflections as Ideas/Images/Associations and Planning

"Reflecting talks" among professionals in a treatment meeting and in front of the family was pioneered by Tom Andersen in (1991). Another version is the "reflective talk" of Seikkula & Arnkil (2006). Both types of reflections are acceptable formats in Dialogic Practice during team meetings. The reflecting process (or talk) occurs among the professionals in the presence of the family. Andersen originally proposed well-defined alterations of talking and listening in the therapeutic conversation with a "reflecting team" (usually 3 professionals) sitting separately, though in the same room as the family, or behind a one-way screen. Making this process more interspersed and spontaneous, Tom Andersen and the Finnish team eventually started to apply the idea of the reflecting process in a less structured way as part of the ongoing flow of the meeting.

As indicated, the talk among the professionals ranges from reflecting upon the ideas, images, feelings, and associations that have arisen in their own minds and hearts while listening to planning the treatment. The purpose is to create a place in the meeting where the therapists can listen to themselves and thus have access to their own inner dialogues.   It also allows the clients' to listen without being under pressure to respond to what the professionals are saying. Following Tom Andersen (1991), the helpers use ordinary language, not jargon, and should be speculative based on the themes introduced by the family. This is called "speaking as a listener rather than as an author" (Lyotard, cited in Seikkula and Olson, 2003).

Case Example of Reflecting Conversation Among Professionals: the L. Family

Returning once again to the first meeting with the L. family of David, Tracy, and Jack described at the beginning, the professionals had a conversation in front of the family, in which they first engaged in reflections and then discussed issues related to treatment.   Therapist 1 started the dialogue by asking the family, "Do you mind if I have a word with my colleague?" The parents said they did not mind. Therapist 2 began by reflecting on what she heard and all the positive things the parents had said about Jack and using their actual words: "sensitive," "loving," "bright," "protective," and so forth. She also repeated fragments of the positive stories. Therapist 1 went on to say that he liked how Jack had participated in the meeting, staying a bit on the outside and listening. Therapist 1 went on to address the issues of treatment and observed that the parents seemed "mixed" in terms of whether to try to find a residential program for Jack or do Open Dialogue.   This statement led to a longer conversation between the therapists that straddled further reflection on the relationships among the family members and practical decisions. Jack and his parents decided they all would like to meet again with these therapists.

C. The Family Comments on the Reflections

After the therapists give their reflections, the family should have a place to say what they think about their discussion. Asking the family to comment on the professionals' talk gives them a voice in their own future. So Therapist 2 asked the L. family: "I am wondering if you have any thoughts about our comments?   What struck you?   What did you agree with?   Is there anything you disagreed with?

Tracy responded by saying: "I think you hit the nail on head. Him (Jack), looking after us. I didn't realize we felt so positively about Jack. (Jack laughs). But, we do." Jack and Tracy both exchanged glances and laughed. David responded to the word "mixed" used previously by Therapist 1, and discussed the various practical options with the therapists.

11. Being Transparent

All treatment talk is shared with all participants. Everyone in the network meeting is equally privy to all discussions and information shared.   This means that all discussion of hospitalization, medication, and treatment alternatives occurs with everyone present. Often transparency occurs as a feature of the reflections. As seen above in the session with the L. family, the treatment decisions were initially addressed as part of the dialogue between the therapists. For instance, as already indicated, the therapist reflected on what he saw as various options in planning the treatment, making his ideas open for discussion, rather than giving an expert recommendation.

Case Example of Transparency: the L. Family:

Therapist 1: "I had a kind of feeling that the parents [David and Tracy] are very mixed in their position about what to do...mixed in the new ideas of coming here and possibly having dialogical meetings and so on. At the same time, it is all a bit uncertain. How much is this decision for the parents, how much is it a decision for Jack himself to make, and how much is this question for the therapists or other professionals to decide?   So there seem to be big issues at the same time that perhaps create a bit of confusion...

This comment, which also illustrates the last element of tolerating uncertainty, evoked a response from the father that led to a clarifying discussion with the parents about their position, which they defined as "not mixed." Rather, both the parents and Jack elected the option of having dialogical meetings and then explore the other alternatives down the road.

At the close of first and often subsequent meetings, dialogical therapists engage the participants in planning the structure of the next meeting. There will usually be such open-ended questions such as: Would you like to meet again? Do you have an idea when? Do you know who might come next time? If the family seems hesitant, the therapists might ask, "Would you prefer to think it over and call us? Of course, if the membership and frequency of the meetings has become established, these questions may be unnecessary.

12. Tolerating Uncertainty

Tolerating uncertainty is one of the seven basic principles of Open Dialogue and one of the key elements of Dialogic Practice. Tolerating uncertainty is at the heart of dialogue. It is thus a specific element and an element that defines the other elements.

In Open Dialogue, there is the fundamental orientation of creating an organic understanding of the crisis with everyone's input (polyphony). This stance is based on the assumption, as well as our experience, that every crisis has unique features. Hasty decisions and rapid conclusions about the nature of the crisis, diagnosis, medication, and the organization of the therapy are avoided. Further, we do not give ready-made solutions such as specific, preplanned therapeutic interventions to the family or the single person in crisis.

The primary idea that professionals should keep in mind in crises is to behave in a way that increases safety among the family and the rest of the social network. Among the specific practices associated with this, it is important to make contact with each person early in the meeting and thus, acknowledge and legitimize their participation. Such acknowledgment reduces anxiety and increases connection and thus, a sense of safety. The availability of the immediate meetings with the team and the frequency of meeting in a crisis also helps the network tolerate the uncertainty of the crisis as the ensemble works toward their own shared understanding of what is frightening and distressing people. Such shared understanding can launch new forms of agency.

In the same spirit, the starting point of a dialogical meeting is that the perspective of every participant is important and accepted without conditions. This means that the therapists refrain from conveying any notion that our clients should think or feel other than they do. Nor do we suggest that we know better than the speakers themselves what they mean by their utterances. This therapeutic position forms a basic shift for many professionals, because we are so accustomed to thinking that we should interpret the problem and come up with an intervention that counteracts the symptoms by inducing change in the person or the family.

Case Example of Tolerating Uncertainty

Helen, a 46 year-old woman, and her husband, Ben, began meeting with an Open Dialogue team at their home during an acute crisis in which Helen was experiencing her second psychotic episode. The team included a psychiatrist, a nurse, and a therapist. In one of the meetings, Helen said:

> "This has been very different compared to my first psychosis a year ago. Then we – my family – met with a doctor whose main interest was interviewing my family members about how crazy I was. As if I was not there. Now it's completely different. I am here and respected. I especially like it when the doctor speaks with my husband and I realize how much my husband respects me."

She had been hospitalized in a traditional psychiatric unit a year earlier. They had had a family meeting at this hospital, but apparently the main purpose of the meeting was to find the right diagnosis. The doctor's questions were geared toward gathering diagnostic information, rather than listening to her and making a connection. This experience had been unsettling for the patient ("as if I not were there").   She articulated the difference between what had happened before and the experience of Open Dialogue. The prior psychiatric interview a year ago left her feeling without power to define her own life and make her own treatment decisions. The more recent dialogical meetings with the team allowed her voice to be heard and for her to feel accepted.

On the other hand, the psychiatrist on the team who was new to this way of working said that, at times, he was very uncertain about what-- if anything-- was happening during this process. In this instance, it was the professional for whom the uncertainty was most intense, because the treatment process no longer proceeded according to concrete, planned steps that are prescribed and controlled mainly by the expert.

If change does occur in the process of Open Dialogue, this may be attributed to the process of engaging everyone's point of view within the meeting. It is therapists' responsibility to conduct the meeting in a way that creates a space where it is safe for everyone to express themselves, in the ways we have outlined above. Finally, the therapists do not simply facilitate polyphony and erase their own voices. They also express their perspectives, but in the form of reflections that they exchange in the presence of the family. Their ideas thus are "overheard" and can be commented upon—and critiqued-- by the network, rather than being "truths" directly imposed in a top-down fashion.

All in all, in a fruitful dialogue, clinicians participate in a human way with feeling and compassion and fulfill their professional roles' with an element of personal warmth. This

promotes a therapeutic connection and avoids being too distant or giving clients the sense that they are being scrutinized or objectified.

CONDUCTING THE TREATMENT MEETING: THE CONTEXT OF OPEN DIALOGUE & DIALOGICAL PRACTICE

In Open Dialogue, the treatment meeting is the context for Dialogic Practice. A treatment meeting should occur as an immediate response within 24-hours of the initial contact from someone seeking help with a crisis. In advance of any decisions about hospitalization or therapy, this meeting brings together the person in acute distress with all other important persons, including other professionals, family members, and anyone else closely involved. It is the responsibility of the professional who took the initial call to organize the meeting, with input from the client(s).

The meeting occurs in an open forum with all participants sitting in a circle. The team members who have initiated the meeting have the responsibility for fostering the dialogue. The team may decide in advance who will conduct the interview and what role the rest of the team will have. Usually if the team is experienced, they start with no prior plan regarding who initiates the questions. All team members can participate in interviewing. The initial, "two questions" referred to earlier invite the network to talk about the issues that are most pressing for them at the present time. The team does not plan the themes of the meeting in advance. From the very beginning the therapists listen carefully and elicit all voices, words, and stories in the manner we have sketched in this document. If the person at the center of concern does not want to participate in the meeting or suddenly runs out of the meeting room, a discussion takes place with the family members about whether or not to continue the meeting. If the family wants to continue, one of the clinicians informs the person that they can return if they want to.

Everyone present has the right to comment whenever they want to. It is advisable that everyone respect and address the ongoing topic of the dialogue, unless clearly proposing an alternate. For the professionals, this means they can respond either by inquiring further about the theme under discussion, or engaging in reflecting dialogue with one another, in which they strive to be open and forthcoming. Therapists speak to –and look at--each other, use ordinary, nonpathologizing language, avoid criticizing family members, and engage in a dialogical exchange with one another. In every meeting, there should be at least some time for the professionals' reflections with each other, because this format is central to generating both

new words for the crisis and an open and shared process that encourages a sense of trust and safety. It is also essential that the network members have an opportunity to comment on what the professionals have said.

Any decisions about medication and hospitalization are made with everyone's input. Discussion of issues related to medication and hospitalization usually occur after family members have had a chance to express their most compelling concerns. After the important issues for the meeting have been addressed, one of the team members usually makes the suggestion that the meeting be adjourned. It is important, however, to close the meeting by referring to the client's own words and by asking, for instance: "I wonder if we could take steps to close the meeting. Before doing so, however, is there anything else we should discuss?" By so doing, the clients have control over the decision to end the session. At the end of the meeting, it is helpful to summarize briefly the themes of the meeting, especially whether or not decisions have been made, and if so, what they were. It is also important to work out the structure of the next meeting if the details are unclear, such as discussing who will attend and when it should take place. The length of meetings can vary, but ninety minutes is usually enough.

SUMMARY

Open Dialogue is both a community-based treatment system and a form of therapeutic conversation that occurs within that system, specifically within the treatment meeting. These two layers of Open Dialogue are guided by the seven principles, of which "dialogue (polyphony)" and "tolerance of uncertainty" are the two fundamental coordinates of therapeutic conversation, or Dialogic Practice. Dialogic Practice in Open Dialogue is the same for both acute crises and more longstanding repetitive, so-called "chronic" situations.

This document has focused on defining Dialogic Practice by identifying and describing twelve, key elements. In the treatment meeting, the principal aim is for the therapists to foster a dialogue in which everyone's voice is heard and respected. The starting point is the language the family uses to describe their situation. The stance of the therapist is different from that of traditional psychotherapy, in which the therapist makes the interventions and does not disclose personal issues. While many family therapy schools concentrate on specific forms of interviewing, the dialogical therapist focuses more on listening and responding to what has touched them.

It is in these moments of "aliveness" in Open Dialogue when a speaker or listener has been touched by something new in the exchange that holds the possibility for transformation. In the prior discussion, we have given examples of these "Striking Moments" (see also, Shotter & Katz, 2007) For example, when Christopher used the word "heartbrokenness," both he and the therapists were visibly moved. Further inquiry yielded a profound shift of perspective afforded by telling a story of what happened to him that placed his experience in a context. There can be sudden revelations and positive movements toward self-healing and wholeness associated with this process that can be profoundly connecting and astonishing. This transformative possibility seems to rely on a therapeutic stance of remaining present and engaged, attuned to ones' own inner dialogue and sensitive to the outer, shared dialogue, responding utterance by utterance as an exchange unfolds. For this reason, professionals hold their knowledge and expertise lightly as part of their repertory of responsiveness. This "Striking Moments" approach is contrasted by Roger Lowe (2005) to a "Structured Methods" approach, which refers to those stepwise and unidirectional sequences guided by external theories and hypotheses.

The Dialogic Practice of Open Dialogue emphasizes "being with" rather than "doing to." There is an open-ended inquiry that emphasizes the present moment. Clients' words and stories are felt to be precious and are carefully attended along with their silences and the whole gamut of gestures, emotions and body-based utterances. The therapists' respond to the clients' expressions by repeating words and listening carefully and try to understand without imposing their own overlay of jargon, interpretation, and hasty conclusions. If someone is difficult to understand, there is an ongoing search for words to give more lucid expression to what they might be trying to say. There is the assumption that the situation is meaningful and that everyone is struggling to make sense of it. New, jointly produced possibilities emerge as new words and stories enter the common discourse. The meeting creates a context for change by generating exchange among the multiple voices all of which are valued and important. Common language and understandings can help undo the tangle of the confusion and ambiguity and produce a greater sense of orientation and agency.

A REQUEST FOR FEEDBACK FROM YOU THE READER

Of note, in order to continue to clarify, refine, and update the 12 key elements of fidelity to Dialogic Practice discussed in this document, we encourage readers to provide feedback on whether this text captures your experience of doing Open Dialogue and Dialogic Practice, helps in reflecting on your work, is useful in training and supervision, and assists in doing

research. We see this text as a living document. Future studies of the reliability and validity of the "The Key Elements of Dialogic Practice in Open Dialogue: Fidelity Criteria" are needed and forthcoming. Please email us and share your comments at: Dialogic.Practice@umassmed.edu.

Thanks – Mary, Jaakko, and Doug   September 2, 2014

ACKNOWLEDGMENTS

We would like to express our gratitude to the families from whom we have learned so much. We thank them for their permission to describe examples from our work together. We have altered theses examples to protect confidentiality and remove any identifying information. We also want to thank our colleagues for their invaluable feedback: Jukka Aaltonen, Volkmar Aderhold, Magnus Hald, Lynn Hoffman, Peter Rober, Markku Sutela, and the UMass Medical School research group, including Daniel Breuslin, Nancy Bryatt, Robert Clyman, Jon Delman, Daniel Fisher, Christopher Gordon, Stephanie Rodrigues, and Makenzie Tonelli.

REFERENCES

Aaltonen, J., Seikkula, J., & Lehtinen, K. (2011). Comprehensive open-dialogue approach I: Developing a comprehensive culture of need-adapted approach in a psychiatric public health catchment area in Western Lapland Project. *Psychosis*, 3, 179-191.

Alanen, Y. (1997). *Schizophrenia: its origins and need-adapted treatment*. London: Karnac.

Andersen, T. (1991). *The reflecting team: Dialogues and dialogues and dialogues*. New York: Norton.

Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). *Milan systemic family therapy: Conversations in theory and practice*. New York: Basic Books.

Hald, M. (2013). The treatment web. *Presentation at the International Meeting for the Treatment of Psychosis Network*. Tromso: Norway.

Hoffman, L. (2007). The art of "withness." In H. Andersen and D. Gehart [Eds.], Collaborative *therapy: Relationships and conversations that make a difference*. New York: Routledge.

Lowe, R. (2005). Structured methods and striking moments: Using question sequences in "living" ways. *Family Process*, 44, 65-75.

Olson, M. (2006). Family and network therapy for a system of care: A pedagogy of hope. In A. Lightburn & P. Sessions, *Handbook of community-based practice.* New York, NY: Oxford University Press.

Olson, M., Laitila, A., Rober, P., & Seikkula, J. (2012). The shift from monologue to dialogue in a couple therapy session: Dialogical investigation of change from the therapists' point of view. *Family Process.* 51, 420-435.

Rober, P. (2005). The therapist's self in dialogical family therapy. *Family Process* 44, 479-497.

Seikkula, J. (2002). Open dialogue with good and poor outcomes for psychotic crises. Examples from families with violence. *Journal of Marital and Family Therapy* 28: 263-274.

Seikkula, Aaltonen, J., Alakare, B., Haarakangas, K., Keranen, J., Sutela, M. (1995). Treating psychosis by means of open dialogue. In S. Friedman, *The reflecting team in action: collaborative practice in family therapy.* New York, NY: The Guilford Press.

Seikkula, J. & Arnkil, T. (2006). *Dialogical meetings in social networks.* London: Karnac.

Seikkula, J. & Arnkil, T. (2014). *Open dialogues and anticipations: Respecting the otherness in the present moment.* Helsinki: THL publications.

Seikkula, J. & Olson, M. (2003). The open dialogue approach to acute psychosis. Its poetics and micropolitics. *Family Process* 43, 4103-418.

Shotter, J. (2004). *On the edge of social constructionism. "Withness-thinking" versus "aboutness-thinking."* London: KCC Foundation Publications.

Shotter J, & Katz, A. (2007). "Reflecting talk," inner talk," and "outer talk:" Tom Andersen's way of being. In H. Andersen and D. Gehart [Eds.], *Collaborative therapy: Relationships and conversations that make a difference.* New York: Routledge

White, M. (2007). *Maps of narrative practice.* New York: Norton.

Ziedonis, D.M. (2004) Integrated treatment of co-occurring mental illness and addiction: clinical intervention, program, and system perspectives. *CNS Spectrum* 9(12):892-904, 925.

Ziedonis, D.M., Smelson, D.A., Rosenthal, R.N., Batki, S.L., Green, A.I., Henry, R.J., Montoya, I., Parks, J., Weiss, R.D. (2005). Improving the care of individuals with schizophrenia and substance use disorders: consensus recommendations. *J Psychiatric Practice* 11(5):315-39.

Ziedonis, D.M., Fulwiler, C, Tonelli, M. (2014). Integrating mindfulness into your daily routine. *Vital signs, A publication of the Massachusetts medical society.* 19:2, 6.