to notice, for instance, unique outcomes and to invite the making of meaning based on these unique outcomes in a way that earlier on would not have been possible or helpful. Maybe, then, there is a similar process available within the open-dialogue process, with more dialogical work being needed earlier on and with more possibilities for the development of preferred stories, accounts and identities as the work progresses?

Conclusions

There seems to be a high degree of compatibility between these approaches. In both, the therapist is no longer an interventionist who assesses, formulates and intervenes.

Being clear about the different roles of the dialogical spaces and the reflecting spaces facilitates the use of narrative approaches in the latter from the beginning of the process; and it seems that this use of narrative therapy alongside open dialogue from early on may help the client move with greater speed to a more helpful understanding of their life.

My thanks to Val Jackson for sharing her understandings of open dialogue so generously and for inviting me to write this article.

References

Aaltonen, J., Seikkula, J. & Lehtinen, K. (2011) The comprehensive open-dialogue approach in Western Lapland: 1. The incidence of non-affective psychosis and prodromal states. *Psychosis: Psychological, Social and Integrative Approaches*, 3: 179-191.

Bakhtin, M. (1986) *Speech Genres and Other Late Essays.* Austin, TX: University of Texas Press.

Holma, J. & Altonen, J. (1997) The sense of agency and the search for a narrative in acute psychosis. *Contemporary Family therapy*, 19: 463-477.

Isaacs, W. (1999) *Dialogue and the Art of Thinking Together: A Pioneering Approach to Communication in Business and in Life.* New York: Currency/Doubleday.

Jackson, V. & Elks, G. (2007) Family intervention and psychosis: The story of the continuing development of family intervention in Aspire, Leeds early intervention in psychosis (EIP). *Context*, 93: 17-18.

Jackson, V. & Gupta, A. (2010) The home-based model of family intervention in early psychosis. *Context*, 110: 39-43.

Jackson, V. & Fox, H. (2014) Narrative and Open Dialogue: Strangers in the night or easy bedfellows? *The Australian and New Zealand Journal of Family Therapy*, 35: 72–80.

Seikkula, J. (2006) *Dialogical Meetings in Social Networks.* London: Karnac.

White, M. (1995) *Re-authoring Lives: Interviews and Essays.* Adelaide: Dulwich Centre Publications.

White, M. (2007) *Maps of Narrative Practice.* London: Norton.

Hugh is a director of the Institute of Narrative Therapy. He teaches narrative therapy internationally as well as offering therapy, supervision and consultation. Email: narrativefox@gmail.com

Widening the dialogue: *Psychoanalysis and open dialogue*

Brian Martindale

Open dialogue emerged from the 'need-adapted' approach to psychosis (Alanen, 1997). This article intends to make a new beginning for a dialogue between that approach and some psychoanalytic approaches relevant to psychosis. In order that open-dialogue practice can continue to be developed and, where appropriate, integrated with complementary areas of knowledge and clinical experience, practitioners and researchers with different clinical orientations and theoretical understandings should engage in ongoing creative dialogues.

Some historical aspects of psychoanalysis with respect to psychosis and open dialogue

Psychoanalysis has had an interest in a theoretical understanding of psychosis since its early days; Freud's analysis of the psychosis of the German judge, Schreber, is an outstanding example (1911). Many psychoanalytic practitioners have been far less pessimistic than Freud about the clinical application of these understandings (1915). Bleuler showed considerable interest in the lives of people who suffered from psychosis and applied the understandings of psychoanalysis (Dalzell, 2011). He observed a more hopeful outcome than the relative pessimism of Freud and the more absolute hopelessness of Kraepelin with his category of 'dementia praecox' (1919).

Sullivan also understood psychosis to be extreme reactions to social and interpersonal environments (1927). Alanen spent time in the USA and came into contact with pioneering psychoanalysts who worked with families who had a psychotic member. Contrary to contemporary beliefs (Martindale, 2008), these pioneers were highly critical of practitioners who blamed families.

Alanen carried out successive cohort-studies and found that outcomes improved further when he introduced family therapy meetings in addition to the already impressive results from individual therapy (1997). A further development was engagement with family members at a very early stage of a person experiencing psychosis coming into the mental health service. These meetings were deliberately not called family therapy, although they were often clearly therapeutic and led to better utilisation of the resources of the family.

The psychoanalyst, Jukka Aaltonen, took Alanen's approach to Western Lapland and was amongst the first to call it 'open dialogue'. Contemporary accounts of the approach, such as Olsen *et al.* (2014), acknowledge its origins in Alanen's work, but without reference to the psychoanalytic underpinnings of the 'need-adapted' approach.

A great deal more detail can be found in Alanen's book and I would stress that it was not a reductionistic approach, in that it did not only understand and treat all psychosis within a psychoanalytic framework. Medication (and the theory of medication) played an important role with many patients as did group and social-milieu practices and aspects of systemic theory and practice; and there was great interest in the Finnish research work of Tienari *et al.* (1994), looking at the nature and nurture interaction in psychosis expressed in the well-known studies of adopted-away children of mothers with 'schizophrenia', looking at differing outcomes according to the adopting family environment.

The organisation of open dialogue

In this article, I am regarding certain organisational aspects of the approach as crucial to its success, in particular the organisation of the whole mental health system (as described by Seikkula in this issue). I will focus on a few psychoanalytic contributions and either their compatibility or their potential complementary contribution to it.

Psychoanalytic concepts

Polyphony and overdetermination

Open dialogue usually has multiple participants and the facilitation of the expression of multiple, separate and potentially equally valid 'voices' within the treatment meetings. This multiplicity of voices within the network is called 'polyphony'. The collaborative exchange among all the different voices weaves new, more shared understandings to which everyone contributes, resulting in a common experience, which Bakhtin (1986) describes as *"without rank"*. Practitioners also emphasise the possibility of inner polyphony in which the therapist engages with the multiple voices of the client. Bakhtin wrote about this stemming from his studies of the prose of Dostoevsky (1984). Each of these voices within (characters) may metaphorically have a life of their own and may sometimes be contradictory or conflicting with the other.

Clearly, this permits all participants to hear multiple perspectives on an issue with enriched understanding. This accent on polyphony has some clear connection with the psychoanalytic concept of over or multiple unconscious-determination of symptoms. In this psychoanalytic framework, improvement results from bringing these multiple determinants into consciousness through the overcoming of resistance to their verbalisation. If the idea of the dynamic unconscious is accepted, the idea of polyphony can be further expanded. In current accounts of open dialogue, it is not clear whether polyphony refers to the bringing to attention of previously unconscious perspectives as well as those that are pre-conscious or conscious in the participants. Most psychoanalysts would probably anticipate there would be some problematic affect that interferes with such verbalisation, resulting in their unconscious substitution or bypassing of affect and the formation of symptoms.

A was a young man who came to an emergency department for help, distressed because he believed that his nice pure mouth-wash had been replaced by street drugs. His mother accompanied him. He was indeed in need of help but it was only after a great deal of careful work, unfortunately some years later, that his mother was able to hear another story from A that, on her redundancy from her job, she was experienced by her son as bringing a bad atmosphere to the home (the poison from the street). The mother would fly into a rage at any criticism, and the father was not yet psychologically available for his son. His presenting story served a potentially useful purpose in engaging his mother in supporting his need for help but unconsciously bypassing the overwhelming negativity that he was on the receiving end of, but which could not be spoken about. There were many other contributory factors to this young man being stuck at home and these other stories could only be voiced step by step. Before psychological therapy started (when it became recognised that A's presenting symptoms reflected human difficulties in his personal and interpersonal life), the approach had been one in which the professional's story was stated that A's problems were the result of a biological illness, an explanation that was understandably very attractive to mother, a belief held with as much conviction by the mother as her son's belief about the mouthwash.

Polyphony, transference and countertransference in psychosis

As stated above, a key aim in open dialogue is to allow all voices to be expressed and to provide a feeling of all being heard and taken seriously. To some extent, the therapeutic team model this approach for family members by both listening attentively and enabling everyone's story to be heard, paying attention to non-verbal communications, making comments that allow for enlargement and empathy and being non-judgemental in all they hear. The practitioners are not focused on change in any quick manner but allowing words to be found for issues in which they had seemingly not previously existed.

A psychoanalyst would readily resonate with this attitude in the way they work, whether with an individual, a group or a family. Perhaps this is even at the core of psychoanalysis: a practice in which every utterance is taken seriously and has potential meaning other than (but not excluding or ignoring) the manifest. Accurate empathy is central to the analyst's own verbalisations, whether these take the form of interpretations or 'empathic description', which stems from a deep identification with the affect of the patient. 'Empathic description' is a term of the Finnish psychoanalyst and theoretician, Veikko Tähkä (1993) for an approach central to facilitating stabilisation of the mind and containment of affect. However, the well-functioning analyst at work is not led by theory, regarding it as a useful servant but poor master. Bion's (1967) aphorism on the best attitude of the analyst being one in which he or she tries to tune into the patient without his or her own memory or desires intruding (e.g. desire for the patient to change) has much in keeping, but long antedates the attempts of the open-dialogue therapist to stay with all that is going on in network meetings without imposing theory or goals.

However, psychoanalysis has a great deal of importance to say about the unconscious processes that can interfere with a therapist of any persuasion who tries to adopt this important attitude. Contemporary psychoanalysis recognises that unconscious transference and counter-transference are a central part of all human relations that have an affective or emotional component. To summarise in simplified form, transference is when a person A attributes and relates to another B with features more determined by the inner world of A than the actual manifestations of person B. Contemporary definitions of counter-transference tend to include all the effects of A on B. It should be stressed that transference and counter-transference are mainly unconscious phenomena, out of initial awareness of both A and B, respectively.

In psychosis, these phenomena are likely to be particularly problematic. For example, someone in a paranoid state will often find it very difficult to sustain a relationship, and this will be even more difficult if the therapist also finds it too difficult to contain the paranoid relationship he or she is tarred with, especially if this has delusional and unpleasant accusatory forces. Particularly problematic responses occur in the client if reassurance is offered. The

well-analysed analyst will tolerate this paranoia and contain it by showing interest in it. Problematic in another direction are idealising relationships in which a therapist may bask oblivious of the 'split off' negativity that is directed elsewhere, perhaps towards other therapeutic colleagues or approaches.

In open dialogue, the team are encouraged to be in dialogue with one another in the presence of the family. However able the therapist trying to follow its principles, an obvious question that arises from these ubiquitous difficult relationships in psychosis is: what are the optimal settings in which therapeutic teams can help one another gain and sustain better insight into the unconscious processes they are subject to? These potential relationship-difficulties are surprisingly little discussed in the open-dialogue literature. It would be naïve in the extreme to believe that the benevolent intentions outlined in the approach, though extremely important, are sufficient to overcome transference and counter-transference manifestations.

Secondary gain and its reduction

The rapid response to any call for psychiatric help has many positive consequences. One that I wish to emphasise is the great reduction in unconscious secondary gain that otherwise readily accrues with passing time after an initial psychological disturbance. As Freud pointed out, secondary gain tends to occur in all cases as time passes and the symptom can become anchored fast in the client's life, and feature as a great resistance to improvement. Open dialogue aims to intervene before secondary benefits have accrued from whatever the equivalents of helplessness are in each case. Helplessness can be exacerbated by prematurely giving diagnostic labels such as schizophrenia.

The increasing familiarity, respect and trust for mental health services by the community as a whole as a result of positive experiences with open dialogue, lead to their earlier use. The investment in involving the family from the earliest stage utilises their resources in supporting the individual's capacities. Aaltonen *et al.* (2011) describe these as two forms of increase in social capital. The open dialogue approach and attitudes contrast with the often poor reputation of services that carry a great deal of stigma, leading to advice to avoid the service for as long as possible.

The unconscious, primary processes and psychosis

I have mentioned above a number of everyday clinical phenomena in psychosis that stem from *unconscious* processes.

In the space available, I can only summarise some psychoanalytic ideas about these. The deeper layers of the unconscious have completely different ways of working (primary processes) compared with (but acting on) the secondary processes of the more rational integrating mind. Primary processes work to relieve pain by bypassing realities, in contrast to secondary processes, which integrate and transform realities including painful ones (Martindale, 2013). In psychoses and dreams, the mind's aim is to try and exclude troubling external and internal realities from secondary

processes, in the search for less painful solutions – extrusion (another term is projection) from self and self-awareness is a common mechanism, as is the breaking up of troublesome thoughts (language) and dispensing with time, memories and affect. Different psychoanalysts place different emphases on what is primary in fuelling psychotic processes (for example, some emphasise too-painful affects and others the fear of annihilation of self or a nameless dread) but what is common to all psychoanalytic theories (stemming from clinical experience) is the idea that psychotic symptoms have an unconscious protective-function. Another important clinical realisation promoted by Bleuler (1950), is the simultaneous co-existence of non-psychotic and psychotic aspects in each of our personalities and this is of very considerable value from both theoretical and clinical perspectives (the non-psychotic aspect being reality orientated, the psychotic aspect aiming at bypassing of displeasure). Here are two simple examples:

The lonely woman who is, never the less, able to get on with her life, but is accompanied by voices being pleasant to her. She does not seek help.

Another elderly woman who is becoming increasingly frail and has lost emotional support and has less and less money, goes to either the police station or the doctor complaining that people are trying to steal all her possessions.

The idea of unconscious processes seem to have little place in presentations of open dialogue and I wonder if the not-inappropriate anxiety about power relationships makes practitioners wary of psychoanalytic 'discoveries'. If this is so, then they are right to be wary of imposing ideas on people with psychosis but, in their anxiety, might be denying themselves and their clients important clues to making sense of why there is no language yet for certain experiences.

Conclusion

This article is no more than an opening dialogue between open dialogue and psychoanalysis. The setting and approach may seem to be radically different from the traditional psychoanalytic method in a number of important ways. In particular, it involves the whole organisational system of a mental health service so that:

- Active early engagement is achieved *of all* people with mental illness and their families in settings of their own choice
- Nearly all professionals are fully trained in a family approach that facilitates all participants being able to reflect empathically in an ongoing process without predetermined hierarchies

The approach has the greatest importance in reducing social stigma in a geographical area and the two key features just mentioned create a framework in which far better outcomes can be achieved than in usual care, according to published outcome-research (Aaltonen *et al.*, 2011; Seikkula *et al.*, 2011).

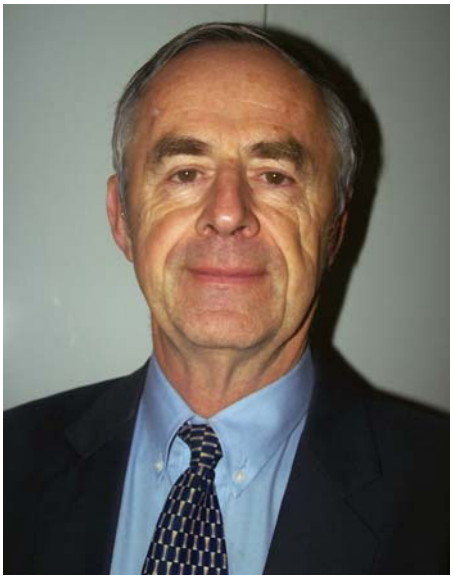
However, I hope I have conveyed that there are many overlapping possibilities for mutual enrichment in the understanding of inter and intra-personal psychological dimensions. There is no need for either open dialogue or psychoanalytic practitioners to ignore each of their hard-gained developments in the field of psychosis and, indeed, it is my belief that the open-dialogue approach can considerably increase its potency by incorporating the understandings stemming from psychoanalysis.

Psychoanalytic understandings of psychotic states of mind follow decades of very careful attention to the human issues involved. These understandings should not be too readily put to one side in the face of the potential revolution of this new approach. It is a giant further step, perhaps almost the ultimate vehicle (outside of primary prevention) on the road back from exclusion of the 'insane' (through excommunication and asylum). But, inside that vehicle, the open dialogue and polyphony needs to continue and be extended to be welcoming of the voices of psychoanalytic practitioners who have also allowed themselves to get close and alongside service-users and families and have developed considerable understanding of the psychotic mind.

My thanks to Jukka Aaltonen for his many helpful comments.

References

Alanen, Y.O. (1997) *Schizophrenia: Its Origins and Need-Adapted Treatment*. London. Karnac.
Aaltonen, J., Seikkula, J. & Lehtinen, K. (2011) The comprehensive open dialogue approach in Western Lapland: 1. The incidence of non-affective psychosis and prodromal states. *Psychosis*, 3: 179-191.
Bakhtin, M. (1984) *Problems of Dostoevsky's Poetics*. Minneapolis: University of Minnesota Press.
Bakhtin, M.M. (1986) *Speech Genres and Other Late Essays* (Trans. by Vern W. McGee). Austin, TX: University of Texas Press.
Bion, W.R. (1967) Notes on memory and desire. *Psychoanalytic Forum*, 2: 279-281.
Bleuler, E. (1950) *Dementia Praecox, or the Group of Schizophrenias* (Trans. J. Zinkin & N.D.C. Lewis). New York: International Universities Press.
Dalzell, T.G. (2011) *Freud's Schreber Between Psychiatry and Psychoanalysis: On Subjective Disposition to Psychosis*. London: Karnac.
Freud, S. (1911) *Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)*. Standard Edition, 12: 3-82. London: Hogarth.
Freud, S. (1915) *The Unconscious*. Standard Edition, 14: 161-215. London: Hogarth.
Kraepelin, E. (1919) *Manic-Depressive Insanity and Paranoia* (Trans. R.M. Barclay). Edinburgh: Livingstone.
Martindale, B.V. (2008) The rehabilitation of psychoanalysis and the family in psychosis: Recovering from blaming. In J.F.M.Gleeson, E. Killackey & H. Krstev (eds.) *Psychotherapies for the Psychoses*. London and New York: Routledge.
Martindale, B. & Summers A. (2013) Psychodynamics of psychosis. *Advances in Psychiatric Treatment*, 19: 124-131.
Olson, M., Seikkula, J. & Ziedonis, D. (2014) *The Key Elements of Dialogic Practice in Open Dialogue*. Worcester, MA: The University of Massachusetts Medical School.
Seikkula, J., Alakare, B. & Aaltonen, J. (2011) The comprehensive Open Dialogue approach in Western Lapland:11. Long-term stability of acute psychosis outcomes in advanced community care. Psychosis 3: 192-204.
Sullivan, H.S. (1927/1994) The onset of schizophrenia. *American Journal of Psychiatry*, 151: 135-9.
Tähkä, V. (1993) *Mind and Its Treatment: A Psychoanalytic Approach*. New York: International Universities Press.
Tienari, P., Wynne, L.C., Moring, J. *et al.* (1994) The Finnish adoptive family study of schizophrenia: Implications for family research. *British Journal of Psychiatry*, 164: 20-26.



Brian Martindale is a psychoanalyst and was previously consultant psychiatrist in an early-intervention in psychosis service in the North East of the UK. He is chair of the International Society for Psychological and Social Approaches to Psychosis, honorary president of the European Federation of Psychoanalytic Psychotherapy and an honorary member of the World Psychiatric Association. Email: bm@bmakm.plus.com