



Therapist attentiveness and negative capability in dialogical family meetings for psychosis

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Jaakko Seikkula (2008) has pointed towards the importance of practitioners working in the present moment in dialogical therapy. Extrapolating from Seikkula's work, this article considers the significance of the qualities of therapist attentiveness, generosity and negative capability in dialogical family meetings for psychosis. It is proposed that these qualities are of particular importance when family meetings occur in crisis situations, as when under pressure practitioners can easily be drawn into prematurely interventionist stances that may unintentionally promote chronicity for the person experiencing psychosis. The value of co-working arrangements in enabling practitioners to maintain attentiveness and negative capability in this work is also considered.

Keywords: dialogue; psychosis; therapist attentiveness; negative capability.

'You have to be confident and relaxed at the same time. You have to be capable – where's that quotation....'. She reached into the muddle of papers on her desk and found a scrap on which someone had written with a green pen. She read: 'capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason – You have to get into that state of mind'. Mary Malone in *The Subtle Knife* by Philip Pullman (1997, p. 92).

Introduction

Recounting his experiences of receiving medical treatment for cancer, Canadian narrative theorist Arthur Frank offers the following story. While a technician was taking blood from his arm, Frank commented to her that she was doing this more skilfully than the other technicians who had previously attempted to do so. The technician responded by briefly advising him about the conditions in which he had a right to refuse professionals access to his body. She then added something that Frank felt transported their encounter to another

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realm of significance, 'Remember', she cautioned, 'everyone who touches you affects your healing' (Frank, 2004, p. 27).

Reflecting on Frank's story has led me to think about how we, as professionals, can touch the lives of those we meet with in mental health services in a manner that supports their journey towards healing and recovery. We carry great responsibilities as professionals, for when we touch people clumsily or harshly, even in the most fleeting of encounters, there is a potential for consequences that may extend through the years. For example, it is commonplace in psychiatry to meet people who have lived much of their lives under a schizophrenia diagnosis and who were informed at an early stage of their difficulties that they should anticipate ongoing disability requiring lifelong anti-psychotic medication. The insertion of an authoritative illness narrative into a person's life at a time of crisis may, in the short term, offer a thirsted-for sense of certainty, but also beckons towards a lifetime of restricted living. The pioneers of family therapy were, of course, particularly alert to the power of such self-fulfilling prophecies (Watzlawick, 1984).

Together with a team of colleagues working in an early intervention for psychosis (EIP) team in the North-east of England, I have been involved in developing family meetings that we offer routinely to the young people (aged 14–34) who enter our service. We try to respond quickly, offering an initial meeting during the early period of contact where we can get to know the family and make them aware that we are available to them as a potential resource. In other words, we aspire to act hospitably by offering an early invitation and to 'touch' the family in this period of crisis and vulnerability in a sensitive manner.

It is my impression that participating sensitively and effectively in this way in family meetings requires of us as professionals a capacity to interact with those present in ways that are, in one sense, simple and ordinary, but which also entail particular qualities of attentiveness and a capacity to be still with the situation – to pause and refrain from becoming overly interventionist. In this article I consider some ways in which this capacity for attentiveness in the present moment can be maintained by staff in the midst of what is often extremely stressful work with families with a member in psychotic crisis.

Family meetings for psychosis

Fadden (2006) has commented that the evidence base for family interventions in severe mental illness is amongst the most compelling in the psychiatric field. This is underlined in the revised National

Institute of Clinical Excellence (NICE) Guidelines for schizophrenia (NICE, 2009) which emphasize the value of working with families. While it has frequently been assumed that the type of family interventions indicated by NICE are those that are based upon cognitive-behavioural therapy principles, no single model is recommended (Brabban, 2009; Webster, 2007). Rather, family interventions are defined by NICE in the following broad terms:

A discrete psychological intervention where family sessions have a specific supportive, educational or treatment function and contain at least one other of the following components:

- Problem solving/crisis management work, or
- Intervention with the identified service user. (NICE, 2009, p. 27)

The NICE guidelines recommend that family interventions should be offered in all cases where the person lives with or is in close contact with relatives. To date, however, most mental health services in the UK have struggled to develop services in line with this guideline. In parts of Scandinavia there has been a stronger emphasis on family therapy in adult psychiatric services (Alanen, 2009). In these areas there has been a focus on partnership, working with families as integral to the service model rather than as a bolt on therapy offered as part of a more traditional, individually focused service (Alanen, 1997; Lehtinen *et al.*, 1996). Amongst the most notable of these Scandinavian models is the open dialogue approach that was developed by Jaakko Seikkula and his colleagues in the western Lapland region of Finland. In this approach the entire psychiatric system is organized around engaging with families and networks from the first point of contact (Seikkula *et al.*, 2001a). Psychosis is conceived of as a 'crisis in language' (Penn 1999) and the aim is for the staff to meet together with individuals in psychosis and all those who are concerned about them and to find a shared language with which to speak about the situation. As Hoffman (2006) notes, the focus of the staff in open dialogue is away from a monological discourse, the aim of which is to remove symptoms, and towards a dialogical focus on finding a shared way of talking about what is frightening people. Inspired by the work of Mikhail Bakhtin, Seikkula suggests that it is through dialogue that meaning develops and change arises (Seikkula, 1993; Seikkula *et al.*, 1995).

In the open dialogue approach the staff aim to respond speedily to the call for help, organizing an initial meeting with the person in crisis

and the network of others who are concerned about the situation within 24 hours. Subsequent meetings are arranged according to the requirements of the situation, with the possibility of coming together as frequently as necessary in the early phase until the initial crisis begins to settle. All decisions about future therapy or treatment, including about medication and hospitalization, occur in these network meetings with everyone present (Seikkula and Olson, 2003). The outcomes from this innovative approach are striking (Seikkula *et al.*, 2001b) and the emphasis on rapid engagement with families and the minimal use of medication and hospitalization make open dialogue of particular relevance for EIP services in the UK.

In working with families in our EIP team we promiscuously draw upon ideas and practices from systemic therapy and family management approaches (McNamee 2004), but we have primarily been influenced by the open dialogue approach.¹ Family meetings are one of a range of therapeutic, practical, social and medical interventions offered by our team, which was developed in accordance with the Department of Health (2001) Policy Implementation Guide for EIP services. We usually suggest that these meetings take place in the family's home, as this helps us to understand and appreciate the context of people's lives. If the young person has been admitted to hospital or the family prefer to meet elsewhere, however, a clinical base is used.

Staff 'presence' in family meetings

In the discussion that follows I will be focusing on what I consider to be a fundamental aspect of dialogical practice with families: the capacity of practitioners to be attentive and present in the manner of their relating to others in therapeutic sessions. This emphasis on therapist attentiveness resonates with recent discussions in the broader psychotherapeutic literature on mindfulness and the therapeutic relationship (Gehart and McCollum, 2008).

In discussing the practice of open dialogue, Seikkula offers the following reflection:

¹ Working in the UK context with its particular policies and professional and practice traditions, we have not attempted to transplant the open dialogue approach into our service culture and team setting. Rather, the members of our family team have been influenced by the ethos of the open dialogue approach, particularly the emphasis on dialogism in family meetings.

Being involved in many projects for developing social network orientation, what is surprising is the often difficult process of learning to be in dialogue with clients and our colleagues in the meetings. Perhaps as therapists we are so used to thinking so much about being skilful in methods and interventions that it is difficult to see the simplicity. All that is needed is to be present and to guarantee that each voice becomes heard. (2008, p. 489).

Seikkula and Trimble (2005, p. 461) also discuss the importance of a quality of 'mutual emotional attunement' for healing to occur. They suggest that if staff do not achieve this relational attunement to 'the immediacy of the moment' (p. 466) in meetings then the process of dialogue can falter.

Seikkula's comment about the simplicity of this approach is intriguing. This simplicity lies in the contention that what is required of staff in a dialogical approach to family and network therapies is to remain present and attentive rather than necessarily to intervene in a technically complex fashion. However, the capacity to practice simply by remaining attentive to the present moment when working with families who are highly stressed and fearful and who may be looking to professionals to do something to make things feel better can feel complex and elusive. In considering how we as therapists can maintain this capacity to remain attentive, to pause and be still rather than become overly instrumental in heated circumstances, I draw upon the interrelated concepts of generosity (Frank 2004) and negative capability.

Staff presence and generous listening

Frank (2004) identifies the significance of what he refers to as generosity in relationships between healthcare professionals and the people using their services. Generosity does not revolve around instrumental tasks or interventions. Rather, it concerns a dialogical quality of relationship and generous listening on the part of the professional; that is, a willingness to hear and be moved by the person's story of suffering. For instance, Frank distinguishes the professional practice of taking a history from hearing the person's story. The history, in this sense, is not the person's story and may, in fact, silence the story. In relation to dialogical family therapy, Hoffman (2002) has also used the term 'generous listening', which for her entails patience, a slowness of pace by the therapist, an orientation towards metaphor and 'a conscious effort to resist the pull of goals and structures that still remain from

previous training' (p. 247). She suggests that this orientation allows space for the unexpected, for unusual thoughts and contributions to occur in meetings.

It is my impression that this dialogical quality of generous listening lies at the heart of our work with families in the EIP service. This is a form of listening that does not arise from our own agenda; not 'through the screen of our own intentions' (Smith, 2003, p. 263), or when we are orientated towards persuasion rather than understanding. Generous listening is perhaps particularly important in working with psychosis, as in the heat of the crisis that has brought the family into contact with services there is great potential for people's capacity to listen to one another to be reduced. The person in psychosis may often be expressing themselves in a manner that evokes alarm or anger in others, leading to heated 'reality disagreements' (Birch 1993, pers. comm.). These reality disagreements have, in turn, the potential to further fuel psychotic communications.

The innovative work of psychiatrist and family therapist Dennis Scott in the field of psychiatric crisis intervention during the 1960s and 1970s highlighted the risk of closure or entrapment in an imprisoning psychiatric identity beginning in such moments of crisis (Reed, 2000; Scott, 1973). When this process of closure becomes established the web of intimate relationships that connects the person to family and significant others is severed and the problem is widely perceived as internal to the individual. The person then comes to inhabit a restricting illness identity, shaped by cultural stereotypes about mental illness, from which they are unable to escape. Hoffman has similarly remarked on a kind of chronification or calcification of problems that can develop over time, 'How often have the problems that people come in with developed a thick, isolating carapace that hardens with time, often trapping other family members within it?' (2007, p. 75).

Hoffman reflects that the aim of dialogical therapies is the prevention of this kind of calcification by creating a relational, dialogical process which connects people together, countering the apartness and isolation that may otherwise arise as a result of the crisis. Similarly, Scott believed that the quality of the interface between professionals and family members is crucial in preventing this kind of closure or chronification from occurring. If this relational interface is to provide a context in which the family may feel sufficiently safe to explore the dilemmas that provoked the crisis, then the professionals involved need to offer a particular quality of attentiveness; a quality that may

easily evaporate in the face of service pressures. Scott (1995, pp. 8–9) comments:

Working in the system can make this simple contact very difficult. Especially in these days where there is much pressure and being answerable to higher authorities who demand treatment by prescription.... There is much anxiety and mistrust. This leads to the imposition of treatment regimes in the name of efficiency. This is a recipe for chronicity. Half an hour spent at the start doing nothing but tuning in and letting go of all ideas as to what should or should not be done can save hours of time and money later.

This raises a question of what is required of us as professionals and of the services we operate in to support us in remaining present and attentive when meeting families who are in the midst of a psychotic crisis. We may, as psychiatric staff, feel under fire; under pressure to act and be seen to know by others (Hawkes *et al.* 2001). Together with a colleague from our team I visited the home of a heterosexual couple in their early twenties with a baby son.² The husband had asked us to become involved because his wife was extremely agitated and anxious, pacing up and down in the living room and speaking in an incomprehensible manner. The onset of these difficulties had been sudden. Attempts by my colleague and myself to help settle the situation and begin a conversation about what sorts of fears might be around did not seem to be helping. After an hour or so of continuing crisis the possibility of hospital admission was discussed, as the presence of the baby in the situation increased all of our worries about risk. A hospital bed was arranged and soon afterwards the sense of tension in the situation reduced to the point that we drove the woman to the hospital in our car rather than arranging an ambulance. In the car her speech became still more lucid, so that we were able to have a thoughtful discussion about some of her worries. As the heat of the crisis subsided I began to feel that we had acted prematurely in organizing the hospital admission, which might easily lead to closure and to underscoring an illness identity for this young woman. Research by Whittle (1996) has shown that psychiatric hospital admission often results in a strengthening of illness narratives for service users and families. I also found myself reflecting upon how my colleague and I might have approached the situation differently and provided a more containing presence. My colleague is a person I like and with whom I feel

² Names and some other identifying features have been altered in the practice examples I have included to preserve anonymity.

comfortable, but we had not worked together in a crisis situation before and this element of unfamiliarity resulted in our being more uncertain of ourselves than we might otherwise have been. What might the outcome have been if we had been able, as Scott (1995, p. 9) recommends, to 'do nothing but tune in and let go of our ideas' about what we should do or what should happen? Perhaps the calmness and lucidity that entered the situation as we drove towards hospital may have come about earlier if we had been able to connect with our capability to be more still and less interventionist.

Negative capability

The formulation of the idea of negative capability occurred in a now famous letter written by the poet John Keats in 1817 to his two brothers. Keats had been on an outing to a Christmas pantomime with his friends, Brown and Dilke. Dilke, as Keats later wrote,

was a Man who cannot feel he has a personal identity unless he has made up his Mind about everything ... Dilke will never come at a truth as long as he lives; because he is always trying at it.

Keats said that negative capability, by contrast, comprises patience and an ability to tolerate frustration and anxiety, a letting go of the sense that we know in order to be in mysteries and doubts.

Writing in a similar vein from the therapy field, the psychoanalyst Wilfred Bion famously advised that the analyst should 'impose on himself a positive discipline of eschewing memory and desire' (cited in Simpson and French 2006, p. 249). Bion argued that the purpose of psychoanalytic training is not theoretical knowledge per se, however important, but the acquisition of this ability to work in the present moment. In other words, it required an openness to what is present, to what arises in the very moment of interaction. In his 'Notes on memory and desire', Bion sets out the following guidance for therapists:

Obey the following rules:

Memory

Do not remember past sessions. The greater the need to 'remember' what has been said or done the more need to resist it ...

Desire

The psychoanalyst can start by avoiding any desires for the approaching end of the session (or week or term). Desire for results, 'cure', or even understanding must not be allowed to proliferate. (Bion, 1988, p. 18)

Commenting on Bion's work, Betts (n.d.) identifies a paradox in attaining negative capability through a set of rules. The notion of a rule infers certainty and a striving to achieve a particular state. Betts questions whether negative capability is something that we strive for or must somehow prepare ourselves and wait for.

Betts suggests several ways in which practicing therapists may prepare themselves for negative capacity, including making quiet, unhurried time available for ourselves; formal meditation practices; avoiding emotionally preoccupying activities between sessions such as difficult phone calls; reading and writing about therapeutic work, which can create opportunities for new ideas 'to arrive'; maintaining sustaining personal and professional relationships and staying connected with the wider therapeutic community. While these suggestions all have great value in enhancing a mindful practice, as a therapist in an often hectic psychiatric service I am particularly interested in what small ways it might be possible in the heat of the practice situation to enhance negative capability. One such way is to find opportunities to take small pauses in the midst of hectic interactions by finding what might be termed 'the dead spot'.

The dead spot

In an interview with a trapeze artist discussed by Zen Buddhist Diane Eshin Rizzetto (2006), the trapeze artist explains that the ability to swing from bar to bar, seemingly without effort, is not primarily a matter of physical strength but is about 'letting the trapeze do the work for you' (p. 31). The trapeze artist went on to explain that the most important part of the trapeze action is finding the 'dead spot', which comes at the end of each swing, 'when the swinging bar stops moving in one direction and starts moving in the other. Like when you're highest on a playground swing. The whole idea is to use that change of momentum to create the trick' (2006, p. 34). The interviewer responded by reflecting that a trapeze act is rather like life, in that timing is all, but added that it can be difficult in life to pause and wait for the right timing to reveal itself. Eshin Rizzetto expands this metaphor by commenting on another aspect of the dead spot, the letting go between bars. She adds that life offers us many such possible moments of letting go, of non-action and not-knowing, when we can be 'open to whatever life brings our way' (2006, p. 33).

In our work with families it can also be helpful to look for moments when we may briefly pause and let go. This can help us to be attentive

to what is taking place in the meeting and to our own inner dialogues in a non-reactive way, placing in abeyance any impulse to intervene or be helpful in a potentially impositional manner (Rober and Seltzer 2010). Some time ago a colleague and I were visiting a family in which a 14-year old girl called Lucy had just been discharged from hospital. Lucy had been admitted because she was hearing voices and taking amphetamines and other street drugs, which led to her becoming increasingly strange in her manner and upset and rather out of control in the home.

As we talked with the family about how things had been since Lucy had returned home, she admitted to her family that she was continuing to use drugs and hear voices and that she had only pretended to the hospital staff that these voices had gone away so that she could go home again. The mood of the meeting immediately intensified, and my anxieties rose that the family would insist that Lucy returned to hospital. My initial impulse in the face of what felt like rather a mess was to try to think of some kind of solution-orientated intervention that might help rekindle a more hopeful mood.

Pausing for a moment before speaking, however, I became more deeply aware of the physical presence of Lucy's Mum sitting next to me, and I gained a strong sense of the huge weight that had descended on her in response to what Lucy had said. The directness of this momentary experience of the despondency that had fallen over Lucy's Mum alerted me to how trivializing it might seem to the family if I were to try to move towards a more positive stance at that moment. Instead, I simply commented on how very difficult the situation felt right now. This acknowledgement of the current reality seemed crucial as a precursor to a future position of greater hope. While such interactions are rather commonplace and, in a sense, unexceptional in psychiatric family work, I believe that an ability to pause and let go of the impulse to act can be crucial to the family's sense of being listened to and feeling safer at a potentially critical moment.

Co-working

Co-working relationships can be extremely supportive of this capacity for momentarily pausing in the sometimes hectic flow of interaction in family meetings, and generally two members of our team facilitate the family meetings we offer. The presence of a close colleague may help to create more breathing space by reducing the sense of pressure that one might experience if working alone to act rapidly to try and make

things better. Also, when a colleague is more active in the meeting in speaking with family members, as Tom Andersen (1990) has pointed out, we have space to pause and be attentive to our own inner dialogues as well as to what is being spoken about between the others present. I imagine if I had been working alone when visiting Lucy and her family, the impulse to try to somehow make things feel better would have overpowered me.

A co-therapy approach also enhances opportunities to promote dialogue and reflexivity by using reflective process formats (Andersen 1990). Reflective processes may be particularly valuable in working with people experiencing psychosis. Lysaker and Lysaker (2004) have argued that for the person in psychosis the capacity to maintain an ongoing dialogue with others, or in one's inner talk with oneself, has become impaired. Since it is through dialogue that we create meaning, a demise in the capacity for dialogue may disrupt or impoverish one's sense of self and of one's experience of the world. By creating opportunities in a meeting for those present to move between speaking (with others) positions and listening (to one's inner conversations as well as to the voices of the others who are present), and by maintaining a tentative and reflective tone and pace, participants may begin to find ways of speaking and listening that are reflective and dialogical in nature.

Additionally, co-working helps to contain staff anxieties, therefore promoting curiosity and creativity and reducing the likelihood of retreating into more traditional professional patterns of thinking or ticking boxes approaches to engagement and assessment. In her discussion of medical practice Connelly (2005) points out that service pressures can lead to a tendency for professionals to react to situations by relying on habitual methods of interaction, assessment and decision-making. These habits may lead to a loss of presence, a loss of awareness and the development of impersonal responses. In family meetings, co-working allows us to share the responsibility and, consequently, the pressure, in such a way that there is likely to be less psychological slippage and a greater likelihood of our being able to remain watchful of our own attentiveness.

Concluding remark

In a moving tribute to the late Tom Andersen, Shotter (2007) discusses Andersen's ability to be orientated sensitively and responsively to his surroundings; of relating to himself, the others he encountered, and

the environment he moved in, in a special kind of way. Shotter reflects that this special quality of relating entailed a keeping, or better, a not losing, what has been described in Zen Buddhism as 'beginners mind'. Zen Master Shunryu Suzuki famously said of 'beginners mind' or 'original mind' that 'In the beginner's mind there are many possibilities, but in the expert's there are few' (2001, p. 21). The beginner's mind entails the capacity to be present in the moment, unrestricted and undistracted by self-centred thought, in sympathy with ourselves and those we interact with.

As Jaakko Seikkula (2008) has commented, dialogical practice also entails being present and responsive to the voices of those we meet. It might be said that such practice requires of us as therapists some capacity to keep or regain our beginner's minds. Suzuki advised (2001, p. 22), 'always be a beginner': cultivating negative capability; and an ability to pause and find the dead spot, particularly in the turmoil of psychiatric crisis work, can be particularly valuable in helping us connect with this.

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References

- Alanen, Y. O. (1997) *Schizophrenia: Its Origins and Need-Adapted Treatment*. London: Karnac.
- Alanen, Y. O. (2009) Towards a more humanistic psychiatry: development of needs-adapted treatment of schizophrenia group psychoses. *Psychosis*, **1**: 156–166.
- Andersen, T. (1990) (ed.) *The Reflecting Team: Dialogues and Dialogues about the Dialogues*. Broadstairs: Borgmann.
- Betts, W. (n.d.) Negative capability. Psychoanalysis Downunder. Issue 7B. Retrieved 11 November 2008 from <http://203.89.196.17/downunder/backissues/696/752/753>.
- Bion, W. ([1967] 1988) Notes on memory and desire. In E. Bott Spillius, (ed.) *Melanie Klein Today: Developments in Theory and Practice*. Vol. 2. London: Karnac.
- Brabban, A. (2009) *NICE – Delivering hope to families?* International Society for the Treatments of the Schizophrenias and Other Psychoses UK Conference, Newcastle-upon-Tyne. 27 February.

- Connelly, J. E. (2005) Using mindfulness in clinical practice. *Perspectives in Biology and Medicine*, **48**: 84–94.
- Department of Health (2001) *The Mental Health Policy Implementation Guide*. London: Department of Health.
- Eshin Rizzetto, D. (2006) *Waking Up to What You Do*. Boston, MA: Shambala Press.
- Fadden, G. (2006) Training and disseminating family interventions for schizophrenia: developing family interventions skills with multi-disciplinary groups. *Journal of Family Therapy*, **28**: 23–38.
- Frank, A. (2004) *The Renewal of Generosity: Illness, Medicine, and How to Live*. Chicago IL: University of Chicago Press.
- Gehart, D. and McCollum, E.E. (2008) Inviting therapeutic presence: a mindfulness-based approach. In S. F. Hick and T. Bien (eds) *Mindfulness and the Therapeutic Relationship* (pp. 176–184). New York: Guilford Press.
- Hawkes, K., Hopkins, C. and Reed, A. (2001) Finding the centre of the cyclone: reflective family work in a crisis intervention team. *Mental Health Practice*, **5**: 14–17.
- Hoffman, L. (2002) *Family Therapy: an Intimate History*. New York: WW Norton.
- Hoffman, L. (2006) Foreword. In Seikkula, J. and Arnkil, T. E. (2006) *Dialogical Meetings in Social Networks* (pp. xi–xv). London: Karnac.
- Hoffman, L. (2007) The art of ‘witness’: A bright new edge. In H. Anderson and D. Gehart (eds.) *Collaborative Therapy* (pp. 63–79). New York: Routledge.
- Keats, J. (1817) Letter to his brothers, 21 December, retrieved 11 November 2008 from <http://www.mrbauld.com/negcap.html>.
- Lehtinen, V., Aaltonen, J., Koffert, T., Rakkolainen, V., Syvalahti, S. and Vuorio, K. (1996) Integrated treatment model for first-contact patients with a schizophrenia-type psychosis: The Finnish API Project. *Nordic Journal of Psychiatry*, **50**: 281–287.
- Lysaker, P. and Lysaker, J. T. (2004) Schizophrenia as dialogue at the end of its tether: The relationship of disruptions in identity with positive and negative symptoms. *Journal of Constructivist Psychology*, **17**: 105–119.
- McNamee, S. (2004) promiscuity in the practice of family therapy. *Journal of Family Therapy*, **26**: 224–244.
- National Institute of Clinical Excellence (NICE) (2009) *Core interventions in the treatment and management of schizophrenia in primary and secondary care (update) National Clinical Practice Guideline No. 82*. Retrieved 2 November 2011 from <http://www.nice.org.uk/nicemedia/pdf/CG82NICEGuideline.pdf>.
- Penn, P. (1999) Metaphors in regions of unlikeness. *Human Systems*, **10**: 3–10.
- Pullman, P. (1997) *The Subtle Knife*. London: Scholastic.
- Reed, A. (2000) Manufacturing a human drama from a psychiatric crisis: crisis intervention, family therapy and the work of R. D. Scott. In P. Barker and C. Stevenson (eds) *The Construction of Power and Authority in Psychiatry* (pp. 151–160). Oxford: Butterworth Heinemann.
- Rober, P. and Seltzer, M. (2010) Avoiding colonizer positions in the therapy room: some ideas about the challenges of dealing with the dialectic of misery and resources in families. *Family Process*, **49**: 123–127.
- Scott, R. D. (1973) The treatment barrier: parts 1 and 2. *British Journal of Medical Psychology*, **46**: 45–67.
- Scott, R. D. (1995) The Barnet Crisis Service. Paper delivered at the 25th anniversary meeting of the Barnet Crisis Service.

- Seikkula, J. (1993) The aim of therapy is to generate dialogue: Bakhtin and Vygotsky in family sessions. *Human Systems* **4**: 33–48.
- Seikkula, J. (2008) Inner and outer voices in the present moment of family and network therapy. *Journal of Family Therapy*, **30**: 478–491.
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keranen, J. and Sutela, M. (1995) Treating psychosis by means of open dialogue. In S. Friedman (ed.) *The Reflecting Team in Action: Collaborative Practice in Family Therapy* (pp. 62–80). New York: Guilford.
- Seikkula, J., Alakare, B. and Aaltonen, J. (2001a) Open dialogue in psychosis 1: an introduction and case example. *Journal of Constructivist Psychology*, **14**: 247–265.
- Seikkula, J., Alakare, B. and Aaltonen, J. (2001b) Open dialogue in psychosis 2: a comparison of good and poor outcome cases. *Journal of Constructivist Psychology*, **14**: 267–284.
- Seikkula, J. and Olson, M. E. (2003) The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Process*, **42**: 403–418.
- Seikkula, J. and Trimble, D. (2005) Healing elements of therapeutic conversation: dialogue as an embodiment of love. *Family Process*, **44**: 461–475.
- Shotter, J. (2007) Not to forget Tom Andersen's way of being Tom Andersen: the importance of what 'just happens' to us. *Human Systems*, **17**: 1–27.
- Simpson, P. and French, R. (2006) Negative capability and the capacity to think in the present moment: Some implications for leadership practice. *Leadership*, **2**: 245–255.
- Smith, R. (2003) Listening from the heart. In, M. Brady (ed.) *The Wisdom of Listening*. Somerville MA: Wisdom.
- Suzuki, S. (2001) *Zen Mind, Beginner's Mind*. New York: Wetherhill.
- Watzlawick, P. (1984) Self-fulfilling prophecies. In P. Watzlawick (ed.) *The Invented Reality* (pp. 95–116) New York: W.W. Norton.
- Webster, J. (2007) Commentary. Training psychiatric teams to do family systems acute psychiatry and developing family-inclusive mainstream mental health services. *Journal of Family Therapy*, **29**: 44–48.
- Whittle, P. (1996) Causal beliefs and acute psychiatric hospital admission. *British Journal of Medical Psychology* **69**: 355–370.