

# Combining the use of open dialogue with narrative therapy

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I have had an interest in open dialogue from a distance for a number of years. It was in my relationship with Val Jackson that I came to have a closer acquaintance with this approach. In a supervisory context, we spent much time talking about her commitment to the development of open dialogue and, in the supervisor role, I learnt a great deal from her.

I have been working from a narrative perspective for a long time, and Val has described a narrative approach to working with families in the context of psychotic episodes (Jackson, 2007, 2010), so we had a good basis for talking about the fit between the two approaches. Over the years, we have had many discussions on this topic and, recently, this led to my being involved alongside Val in running workshops for mental health practitioners on open dialogue. I think that this makes it clear that Val and I concluded there was a good fit between these approaches!

The open-dialogue approach does not preclude the use of other therapeutic approaches. It is a development of the needs-adapted approach (Aaltonen *et al.*, 2011). As such, it specifically indicates that, when the initial crisis has passed, clients may be referred for work in any of the other therapeutic modalities, according to need. The therapist would then be invited to attend network meetings.

In this sense, to ask if narrative therapy and open dialogue are consistent seems unnecessary. On the other hand, it might be that some approaches fit very well with open dialogue and others less well. Or, it might be that its principles are not consistent with those of other approaches.

This article seeks to explore this fit and proposes the idea that a narrative orientation is helpful in the practice of open dialogue.

## Dialogue and dialogism

What is dialogue or, as Seikkula distinguishes, dialogism? It requires that the other in a dialogue is seen not as an object but as another 'I', and the thrust is not towards interpreting, diagnosing or hypothesising, but towards understanding,

and to the emergence of new meanings between the various interlocutors:

*Although the term "dialogue" is used for describing all sorts of discussions, dialogism is more of an epistemological stance. There is no longer a single subject who does the thinking; the thinking subject is all the participants in the dialogue (Seikkula, 2006, p. 97).*

These understandings speak strongly to my experience as a narrative practitioner. I seek to create a listening space where the others in the dialogue will have the experience of being listened to and understood. It is the shift from listening in order to assess or to develop hypotheses to listening in order to understand the experience of the others involved. In this process new thinking emerges in the space between us.

## Narrative, dialogue and embodiment

Whilst this may appear to overlook all the 'work' that a narrative practitioner does in terms of narrating new stories (making exceptions visible, building meaning on them, historicising the meaning, and so on), this work only comes later in the process. The initial response can be seen as dialogical. In teaching, I have often referred to therapy as a human encounter (White, 1995). All this fits with open dialogue's emphasis on bodily responses in dialogue and responding as people. It is about being present as a person in the interaction rather than as an impersonal, objective professional.

Further, if we think of dialogism as being the initial response to a crisis in open dialogue, a response that can subsequently lead to other therapeutic modalities being used, then we can think of this as paralleling the process in narrative therapy where people's experience must be heard and acknowledged before engaging in re-storying.

## Responding to psychotic expression

In open dialogue, psychotic expression is seen as a response to behaviour that

does not yet have words. Part of the task of dialogism is for the thinking between people to lead to the development of language for that which cannot be said. Again, this fits precisely with my experience of narrative practice. There is careful attention at the level of the word to what is said and, together, we think in ways to create new language that more closely expresses the experience of the people who have come for consultation.

What is important in both approaches is the acceptance of whatever is uttered in a literal way. It is not the task of the worker in either approach to interpret or give meaning to what is said. The focus is on the words said and the desire to let the speaker know that they have been heard and that their words are taken seriously. Seikkula said at a workshop in Leeds (December, 2007), "It is very simple: all you have to do is to let people know that they have been understood and that what they have to say is important". Careful listening to the speaker's word is fundamental to dialogism and also to narrative therapy and, in both approaches, an important practice is for the worker to use the exact words of the speaker.

This attention to both what it is people say and to their experience leads both approaches to treat hallucinations and voices seriously. Traditional mental health practice has suggested that these experiences should either be ignored, in order not to 'encourage' them, or else 'reality oriented' by saying that they are not real but are a part of the person's illness. Although there has been some recent cultural shift due to the influence of CBT, this shift is not pervasive and traditional approaches remain largely dominant in, for instance, the training of nurses. These sorts of responses are of course disqualifying of the significance of the person's experience, and position the worker as the dispenser of truth. In both open dialogue and narrative, the worker, instead, shows interest in these expressions and invites more conversation about them rather than less. Seikkula suggests questions such as:

*“Wait a moment – what did you say? I did not follow. How would it be possible for you to control your neighbour’s thoughts, I have not done that. Could you tell me more about it, please? When did it start? Does it happen all the times or only in the mornings or nights?” (2006, p. 133)*

This fits with narrative practices of encouraging conversations with the voices that voice-hearers experience and taking all experience seriously.

### Differences in the approaches

If all this is coherent with narrative practice, what are the differences? First, narrative therapy has relatively little to say about organisational issues. However, the emphasis in open dialogue on convening the network of people who are concerned about the problem fits with narrative therapy’s emphasis on social context and on the recruiting of audiences, in particular families.

Secondly, narrative does not specifically theorise the meaning of psychotic expression. Open dialogue sees psychotic expression as response to life experience, and specifically:

- *A strategy to manage difficult experiences*
- *Hallucinations are metaphors for real events*
- *Expression of experiences that do not yet have words*

(Val Jackson, workshop notes, 2013).

These understandings would, however, be perfectly consistent with narrative therapy.

Thirdly, open dialogue does not seem to say anything about where to go after the crisis has been dealt with, except in the general sense that the person should be offered appropriate therapies and that network meetings should continue. Where narrative therapy is clear about processes for resurrecting old meanings or establishing new ones, in open dialogue this gets less emphasis but is seen as arising out of the dialogism. But the focus on ‘change’ is not the primary objective:

*The focus is primarily on promoting dialogue and secondarily on promoting change in the patient or in the family. Dialogue is seen as a forum through which families and patients are able to acquire more agency in their own lives by discussing the problems (Holma, 1997). A new understanding presupposes a dialogical conversation. New meanings are generated as if in the area between those participating in the discussion (Seikkula, 2006, p. 61).*



Thus, in theory at least, in an open-dialogue approach, the dialogue is where the change happens and nothing more might be seen as necessary. It is interesting to note the reference to agency: again, this fits with the strong emphasis in narrative therapy on developing a sense of personal agency.

### Reflections, narrative and therapeutic efficacy

However, Jackson (2014) suggests the reflecting team process may provide a context for inviting consideration of hopes and of values in line with narrative concerns. She says, whilst discussing a case illustration:

*In alignment with both approaches [open dialogue and narrative therapy] ... I was trying to stay close to the exact words spoken by family members, repeating back what I heard, and only introducing new thoughts in reflections [between the professionals]. Dialogical questions were only used to clarify the telling, not lead towards differing understandings (Jackson & Fox, 2014).*

This, in turn, fits with what Seikkula says about separating listening from speaking through the use of reflecting teams (2006, p. 17) or, more properly, through the use of spaces for the professionals to reflect in front of the family.

Further, discussing the same case, Jackson writes:

*I was very aware that the parents were close to breaking point and that the father did not want to be there. I therefore wanted to create a space for forgotten, or absent but implicit narratives to emerge. In the [reflecting] conversation ... openings to three such implicit narratives emerged*

*... Questions that fitted with a narrative approach opened the possibility to unearth these three possible preferred narratives that could be of assistance to the family.*

*In this situation, I felt time was of the essence. Not having the possibility of meeting the following day, as would occur in the ‘open dialogue’ approach in Finland, I felt some pressure to create conditions for further family collaboration and continuing dialogue ... Perhaps if we knew that we would be able to meet again within 24 hours, then a more dialogical approach of listening and acknowledging words would have been enough (Jackson & Fox, 2014, pp. 77-78).*

The implication is clear: that using some narrative ideas, but in the reflecting spaces rather than in the dialogic spaces, can help things move more rapidly. As long as therapeutic violence is not enacted on the family, this seems a good outcome. This suggests that we might see narrative therapy, used with care, as an adjunct to open dialogue, even in the early stages of work. The separation of the space into dialogic space, where the role of the professionals is primarily to listen, and into reflecting space (for the professionals to reflect and the family to listen) can facilitate the introduction of alternative and preferred accounts without interfering in the dialogic nature of the process. This is similar to the use in narrative therapy of outsider-witness practice to reflect back to the person(s) at the centre, preferred accounts of their identity.

My own experience of working with people has led me to notice that, earlier in the work, it is important to do a lot of listening (be dialogical) and that later in the process it is possible to be more reflective,

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.

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# Widening the dialogue: Psychoanalysis and open dialogue

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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.