Becoming Dialogical: Psychotherapy or a Way of Life?

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After birth the first thing we learn is becoming a participant in dialogue. We are born in relations and those relations become our structure. Intersubjectivity is the basis of human experience and dialogue the way we live it. In this paper the dilemma of looking at dialogue as either a way of life or a therapeutic method is described. The background is the open dialogue psychiatric system that was initiated in Finnish Western Lapland. The author was part of the team re-organizing psychiatry and afterwards became involved in many different types of projects in dialogical practices. Lately the focus has shifted from looking at speech to seeing the entire embodied human being in the present moment, especially in multifarious settings. Referring to studies on good outcomes in acute psychosis, the contribution of dialogical practice as a psychological resource will be clarified.

Keywords: dialogical, psychotherapy, psychosis, psychiatric, outcomes

I was invited to write a paper on open dialogues or a related subject for the *ANZJFT*, which I was delighted about. The editor's proposal was to write about how to become a dialogical therapist. I was enthusiastic about the possibility, but at the same time a bit confused, because speaking of dialogism as a form or method of psychotherapy makes me feel uneasy. I have come to see dialogue or dialogism as a way of life that we learn straightaway after birth: First we learn to breath — inhaling and exhaling, and immediately afterwards we learn to be an active participant in dialogical relations, where we respond to the expressions of those around us and actively initiate their responses to our expressions (Bråten, 2007; Trevarthen, 2007). How could I see this ordinary, everyday process as a therapeutic method? With the risk of sounding a bit hypocritical, I see dialogue simply as something that belongs to life, not as a special therapeutic method. And this means all psychotherapies have to be dialogic if they are to be successful in bringing about the positive changes that psychotherapists seek.

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So if the reader will excuse me, I would like to begin to open up this question in more detail. Honestly, I do understand what the invitation was for, and really want to explore more how dialogical ways of being in professional life and psychotherapy have become for me the choice that makes all the difference. In my professional practice, what has become most important is to improve services for clients who are experiencing severe crises, like psychosis or severe depression. Applying a dialogical approach means mobilising the psychological resources of both the patient and the family members. By understanding the choices made along the way we can learn what the dialogical approach has to offer therapists working with severe mental health crises and other types of challenging situations.

The *dialogical* approach in Finland is at the heart of what we call special *methods of therapy* in psychological treatment. In what follows, I explore the development of open dialogues in Western Lapland in Finland and then describe the approach and evidence for its effectiveness from numerous scientific studies.

From Single Psychotherapy Methods to Integration

My basic education was as a clinical psychologist, and from the very beginning — or even before my training — I had a primary interest in psychotic problems and schizophrenia. My master's thesis had already involved me in an interesting project conducted by Professor Antero Toskala about risk factors for mental health. We studied what factors at preschool age could be used to predict a high risk of developing psychosis in later life.

After graduating, I moved to work at the Keropudas Hospital in Finnish Lapland. We were a small but enthusiastic group of professionals that included two doctors (Jyrki Keränen and Birgitta Alakare), two nurses (Ilkka Vehkaperä and Telma Hihnala), and two or three psychologists (first myself and a couple of years later, Kauko Haarakangas and Markku Sutela), who were all interested in developing a family-centered approach for the most severe mental health problems. We all followed the Finnish Need-Adapted tradition initiated by Professor Yrjö Alanen and his team, including Professor Jukka Aaltonen, who came as the supervisor of the development project in Western Lapland.

When we began to develop the acute psychiatric inpatient system at Keropudas Hospital in Tornio we had two primary interests. First, we were interested in individual psychotherapy for patients diagnosed with schizophrenia. At that time Keropudas Hospital was occupied by dozens of long-term patients who had been considered 'incurable'. What was important in the Need-Adapted tradition was the shift to a more optimistic treatment model and learning how to work with the psychological resources of patients with psychotic problems; finding ways to make use of patients' own psychological resources in our treatments has proved to be crucial.

In Finland, psychotherapeutic practice has long been a part of public health care. And especially important has been the development and research in the Turku psychiatric clinic since the 1960s by Professor Yrjö Alanen and his team. Starting with individual psychodynamic psychotherapy, the Turku team integrated systemic family therapy into their treatments in the late 1970s, and called the approach

Need-Adapted Treatment. This emphasised that every treatment process is unique and should be adapted to the varying needs of each patient. The Need-Adapted Treatment model was also fitted into the context of the Finnish National Schizophrenia Project in the 1980's.

The revolutionary aspects of the Need-Adapted approach were to focus on: (1) rapid early intervention in every case; (2) treatment planning to meet the changing and case specific needs of each patient and family by integrating different therapeutic methods in a single treatment process; (3) having a therapeutic attitude as the basic orientation for each staff member in both examination and treatment; (4) seeing treatment as a continuous process; and (5) constantly monitoring treatment progress and outcomes (Alanen, 2009; Alanen Lehtinen, Räkköläinen.,& Aaltonen, 1991).

In the era of evidence-based medicine all this sounds very radical, because it challenges the idea that therapists should choose the one right method of treatment after first doing an accurate diagnosis of the case. By contrast, Need-Adaptiveness focuses on the idea that the 'right' diagnosis *emerges* in joint meetings; and it became clear to us that the process of understanding, that is, arriving at a full and practical understanding in a dialogic manner by all concerned of what has happened, can itself be a very therapeutic process.

Anticipating psychotherapy research into common factors, the Need-Adapted approach already in the early 1980s was integrating different psychotherapies, instead of choosing one school or approach; for example, just systemic family therapy or individual psychodynamic psychotherapy. In my personal development this has probably been one of the most important aspects guiding me and my co-workers to always look across the boundaries to the neighbour's side.

Open Dialogue in the Therapy Meeting

One of the most striking innovations of the Need-Adapted approach was the idea of open treatment meetings. The idea was described to us by the Turku team in 1984 while we were experiencing frustration about not finding ways to integrate individual psychotherapy with a schizophrenia patient and systemic family therapy for their families. In the beginning, these two methods seemed to be far from each other, although we were the very same therapists doing this interesting work. At this point, we heard about the open meetings, in which both patients and their family are invited from the very beginning, without any staff members preparing the meeting. In Turku, the team-work approach was always preferred for a person's admission, rather than interviews by the doctor or psychological testing by the psychologist.

In this treatment meeting the major participants in the problematic situation join with the patient to discuss all the relevant issues. All management plans and decisions are made with everyone present. The meeting takes place in an open forum and all participants sit in a circle in the same room. The team members who have taken the initiative for calling the meeting begin the dialogue, but there is no prior planning regarding who asks questions; thus all staff members can participate in interviewing.

The first questions are as open ended as possible, to guarantee that family members and the rest of the social network can begin to speak about the issues that are most relevant at the moment. The team does not plan the themes of the meeting in advance. From the very beginning the task of the interviewer(s) is to adapt their answers to whatever the clients say. Most often, the teams' answer takes the form of a further question, which is based on and has taken into account what the client and family members have said. Often this means repeating word by word some part of the utterance and encouraging further speaking on the subject.

Everyone present has the right to comment whenever s/he is willing to do so, but comments should not interrupt an ongoing dialogue. Every new speaker should adapt his/her utterance to what was previously said. For the professionals this means they can comment either by inquiring further about the theme under discussion, or by commenting reflectively to the other professionals about their thoughts in response to what is being said. Most often, in those comments, specific phrases are introduced to describe the client's most difficult experiences.

Staff members inform the family about their obligations towards the end of the meeting, after family members have spoken about the most compelling issues for them. After the important issues for the meeting have been addressed, the team member in charge of calling the meeting suggests it be adjourned. It is important, however, to close the meeting by referring to the clients' own words and asking, for instance: 'I wonder if we could begin to close the meeting. Before doing so, however, is there anything else we should discuss?' At the end of the meeting it is helpful to briefly summarise the themes, especially whether or not decisions have been made, and if so, what they were. The length of meetings can vary, but usually 90 minutes is adequate.

As the reader can see, our approach in many respects is resonant with the dialogical, language-based family therapy of Harlene Anderson and Harry Goolishian (1988), which was later developed by Anderson (1997) into collaborative therapy. We also found a resemblance with Tom Andersen's (1991) work on reflective team dialogues and processes. Interestingly, these approaches developed about the same time, but we only became aware of them later on, which gave us support to move in the direction we had chosen.

This open way of working was very enthusiastically received from the beginning, which encouraged us to proceed, but quite rapidly we started to have confusing and unexpected experiences. Later we realised this was a consequence of the patient and family being actively involved in the process of understanding the problem and planning the treatment. We could no longer follow the traditional idea of first planning and then conducting a treatment approach. Also, we confronted various therapeutic impasse situations, which were negotiated by adapting our interventions to how the family was talking about and living the actual crisis.

Our view of psychiatric and family therapeutic treatment was challenged in the following ways:

• Treatment planning with stable plans was not possible, but every meeting generated a new plan as a process. This process of planning and re-planning the treatment was very helpful.

- We could no longer apply the idea of the therapist as initiating the change in the family system by different family therapy interventions.

- We realised family work was possible in a public sector inpatient setting, although the Milan team had said that a prerequisite for systemic therapy is to stay away from the institution (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1978).

- While systemic family therapy seemed not to be the solution, we were 'forced' to look for other options. Systemic family therapy focused on seeing the problem or symptoms as a function of the family system. But in generating open dialogue we aimed at having all the different voices being heard, without any idea whether they had a function in the family system. Thus the intervention was not to initiate change in family interaction, but to generate new words and narrate new happenings.

Meeting with Dialogism

In our first efforts we saw open meetings simply as a forum for organising the treatment rather than basing them in dialogic ideas at a formal level. However, while reflecting on some of our confusing experiences in the meetings, we became aware of the writing of the Russian linguist and literature researcher Mikhail Bakhtin on a polyphonic way of life and dialogism.

I first read about Bakhtin in a paper written in the Russian language by a professor at the University of Jyväskylä, Erkki Peuranen (1980). I was astonished that Bakhtin (1984) seemed to describe the same experience in Dostoevsky's novels that we were experiencing in the 'polyphonic' meetings with our clients. There were always many voices present in the treatment meetings, and as Bakhtin notes, in a polyphonic meeting the position of every participant, especially the author, is changed radically. The only way to proceed is to generate dialogue between all the participants' voices, and in this polyphony no voice can be more important than others.

According to Bakhtin (1984), the author of a polyphonic novel cannot control the action of the characters, and the only way to survive is to be in dialogue with them. We realised we were this type of 'author'; we had the responsibility for authoring the story of the treatment, but could no longer do so in the traditional way, where we define methods and interventions to remove symptoms or change the family system.

In open dialogue meetings the focus is strengthening the adult side of the patient and normalising the situation instead of focusing on regressive behavior (Alanen et al., 1991). The starting point for treatment is the language of the family in describing the patient's problem. Problems are seen as socially constructed and are reformulated in every conversation (Bakhtin, 1984; Gergen, 2009; Shotter, 1993; Shotter & Lannamann, 2002). All persons present are encouraged to speak in their own unique voice.

Unlike traditional therapy, the stance of the therapist is not to make an intervention. Also, while many family therapy schools are especially interested in creating

specific forms of interviewing, in open dialogue *listening and responsively responding* becomes more important. Team members can comment on what they hear to each other as a reflective discussion, while the family listens (Andersen, 1995).

Open Dialogue as Psychiatric System

For me the open meetings were closely connected to the public psychiatric services in Western Lapland. The name *Open Dialogue* was first used in 1995 to describe the entire family and social network-centred treatment (Seikkula et al., 1995). It included two aspects: First, the meetings described above, in which all relevant members participate from the outset to generate new understanding through dialogue. Second, it provided the guiding principles for the entire system of psychiatric practice in one geographic catchment area. This meant that for us open dialogue was not only a way of conducting open meetings with a patient and the family, or even including part of the social network. It also provided basic principles for organising the whole psychiatric treatment system in a way that made dialogue possible.

In developing the new approach, we realised the importance of research into the psychiatric system in Western Lapland. For developing dialogical practices this has been one of the three most important elements. Several effectiveness and treatment process evaluations of the Open Dialogue approach have been completed by employing action research ideas (Aaltonen, Seikkula, & Lehtinen, in press; Haarakangas, 1997; Keränen, 1992; Seikkula, 1991, 1995; Seikkula et al. 2003, 2006, 2011). Action research consists of a method and design that makes it possible to study human systems from within, where the researcher is a part of the system being observed. In these studies we realised the extraordinary resource in the system to produce positive outcomes for psychotic and depressive patients that are better than any other approach, especially for psychosis. The studies also provided optimal principles for organising psychiatric treatment in the most severe crises, which focus on mobilising the resources of families and other social networks of the patient.

According to these principles an optimal system for mobilising the psychological resources of our client should include: (1) an immediate response by having the first meeting within 24 hours after contact; (2) a social networks perspective that in all cases invites relevant members of the client's social network and all the professionals involved in the actual crisis; (3) flexibility and mobility by always adapting to the unique needs of every client and family; (4) guaranteeing responsibility, so that whoever is contacted in the professional system becomes responsible for organising the first meeting before any decision is made concerning the treatment; (5) psychological continuity by integrating staff from different services, like child psychiatry, outpatient mental health and so on, if needed — to work as an integrated team for as long as required; (6) tolerating uncertainty and generating a process for the new conversational community to 'live' and talk together; and (7) dialogicity as the primary aim in the joint meetings, to increase understanding about the actual crises and the life of our customers. By 'dialogism' I mean both, responsive understanding and taking family members into explorations they would not otherwise undertake.

Open dialogues has been systematically studied in Western Lapland with first episode psychotic patients (Seikkula et al., 2006; Seikkula et al., 2011; Aaltonen et al., 2011). These studies have shown favourable outcomes in psychosis. At 5-year follow-up 85 % of patients did not have any remaining psychotic symptoms and 85% had returned to full employment. Only one third used antipsychotic medication. There is also some evidence that in Western Lapland the incidence of schizophrenia has declined during the 25 years of the open dialogue practice.

The Present Moment in Polyphonic Embodied Dialogues

What is described above sets the context for my personal understanding of psychotherapeutic work. It is not a generalised model, but specifically relates to the development of the project in Western Lapland for dealing with the most severe mental health crises. During the last 20 years I have been involved in developing dialogical practices within many types of contexts and with many types of client, children, adolescent, adults and families. It is possible to apply dialogical approaches in many different settings.

But what has surprised me is the enormous difficulty therapists with extensive experience in a particular therapeutic method have in adopting a dialogical way of working with clients. For as I see it, dialogue is not a method; it is a way of life. We learn it as one of the first things in our lives, which explains why dialogue can be such a powerful happening. Because it is the basic ruling factor of life, it is in fact very simple. It is its very simplicity that seems to be the paradoxical difficulty. It is so simple that we cannot believe that the healing element of any practice is simply to be heard, to have response, and that when the response is given and received, our therapeutic work is fulfilled (Seikkula & Trimble, 2005). Our clients have regained agency in their lives by having the capability for dialogue.

How does this happen? For therapists the main challenge becomes being present in the moment, as comprehensive embodied living persons, and responding to every utterance, and thus living in the 'once-occurring participation in being' (Bakhtin, 1993, p. 2).

Tom Andersen (2007) was preoccupied by three different realities of our practices as social and health care professionals: (1) In the 'either–or' reality we handle issues that are visible but dead, in the sense that they are exactly defined and the definitions remain the same in spite of the context. (2) In the 'both–and' reality we deal with issues for which many simultaneous descriptions are possible. These issues are living and visible. This is the case, for instance, in family therapy discussion, when we make space for different voices to become heard without considering one point of view to be right and another wrong. (3) In the third, the 'neither–nor' reality, things are invisible but living. We experience something as taking place, but we do not have an exact linguistic description for it. We may say that it is neither this nor that, but I know that something is taking place. As an example, Andersen gives handshaking. It is something that happens in our embodied participation in the session, yet it is not commented on by words, but remains as our embodied experience.

Daniel Stern (2004), in emphasising the importance of the present moment, is critical of descriptions of psychotherapy and psychoanalysis that focus on clients' narratives. The therapist is seen as the one giving meanings to patients' stories in different schools in different ways. Therapy deals with explicit knowledge in linguistic descriptions. Stern proposes moving from explicit knowledge to the implicit knowing that happens in the present moment as embodied experience, and mainly without words — that is, becoming aware of what is occurring in us *before* we give words to it. We live in the present moment lasting only few seconds. This refers to the micro aspects of a dialogue in the response and responsiveness of the therapist to the person before anything is put into words or described in language; that is, in being open to the other.

In the type of family therapy that focuses on generating dialogues this means shifting the focus from the *content* of narratives to the unfolding feelings in the present moment when narratives are told. Therapists and clients live in a joint, embodied experience that happens before the client's experiences are formulated in words. In dialogue an intersubjective consciousness emerges. Our social identity is constructed by adapting our actions to those of others; and even more, knowing me myself as such is only possible by me seeing myself through the eyes of the other (Bakhtin, 1990). Living persons emerge in real contact with each other and adapt to each other, as in a continuous dance in which automatic movements occur, without controlling and deliberating on their behavior in words.

The intersubjective quality of our consciousness is shown in the mother–baby communication studies conducted by Trevarthen (1990; 2007). Trevarthen's careful observations of parents and infants demonstrate that the original human experience of dialogue emerges in the first days of life, as parent and child engage in an exquisite dance of mutual emotional attunement by means of facial expressions, hand gestures and tones of vocalisation. This is truly a dialogue: the child's actions influence the emotional states of the adult, and the adult, by engaging, stimulating and soothing, influences the emotional states of the child.

Bråten (1992, 2007) describes the Virtual Other as an innate part of the baby's mind that, in a way, waits for a dialogue with the Actual Other. If the Actual Other is not present, the dialogue emerges with the Virtual Other. Near relations take place in the mode of felt immediacy, in feelings that are felt in a pre-linguistic form (Seikkula & Trimble, 2005).

In every meeting two histories happen. The first is a history generated by our presence as embodied living persons. We adapt ourselves to each other and create a multi-voiced polyphonic experience of the shared incident. Salgado and Hermans (2005) point out that we cannot call this 'experience', because experience already presumes psychological meaning that is included by the Other or Otherness in the situation. It is our embodied experience for which manifold meanings emerge, based on the number of participants in the situation. Family sessions as such already include several family members and often two or three therapists. Most of this history takes place without words, but not all. The words that refer to our presence in this conversation often include the most important emotions connected to those voices of our lives that deal with difficult experiences. We may, for example, describe and reflect on our feelings about the specific situation we are talking about.

The second history in the same situation occurs in the stories that living persons tell of their life. Stories always refer to the past; they never can reach the very present moment, since when the word is formulated, and when it becomes heard, the situation in which it was formulated has already passed. Integrating the two aspects of the same moment, it becomes evident what the focus on dialogue can add to a narrative orientation. As Lowe (2005) stated: 'The conversational style . . . simply *follows* the conversation, while the narrative and solution-focused styles often attempt to *lead* it' (p. 70, my emphasis).

Compared to narrative and solution-focused therapies, in dialogical approaches the therapists' position becomes different. Therapists are no longer interventionists with some preplanned map for the stories that clients are telling. Instead, their main focus is on how to respond to clients' utterances, as their answers are the generators for mobilising the client's own psychological resources — since 'for the word (and consequently for a human being) there is nothing more terrible than a lack of response' (Bakhtin, 1984, p. 127). Respecting the dialogical principle that every utterance calls for a response, team members strive always to answer what is said. Answering does not mean giving an explanation or interpretation but, rather, demonstrating in a therapist's response that one has noticed what has been said and, when possible, opening up a new point of view on what has been said.

This is not a forced interruption of every utterance to give a response, but an adaptation of one's answering words to the emerging natural rhythm of the conversation. Team members respond as fully embodied persons, with a genuine interest in what each person in the room has to say, avoiding any suggestion that someone may have said something wrong. As the process enables network members to find their voices, they also become respondents to themselves. For a speaker, hearing her own words after receiving the comments that answer them, enables her to understand more of what she has said. Using the everyday language with which clients are familiar, team members' questions facilitate the telling of stories that incorporate the mundane details and the difficult emotions of the events being recounted.

Polyphony of Voices

Seeing our consciousnesses as intersubjective abandons the frame of seeing individuals as subjects of their lives, in the sense that the coordinating centre of our actions exists within the individual. Instead, a description of the polyphonic self is generated. So the polyphonic self is socially constructed but in a way that is uniquely named as response and responsiveness. Already Plato in his early works saw self as a social construction when saying: 'When the mind is thinking, it is simply talking to itself, asking questions and answering them, and saying yes or no. When it reaches a decision — which may come slowly or in sudden rush — when doubt is over and the two voices affirm the same thing, then we call that "its judgement"' (Plato, Theatetus, 189e–190a).

The mind is a continuous initiating and responding of voices speaking to each other. Voices are the speaking personality, the speaking consciousness (Bakhtin, 1984; Wertsch, 1991). Personality is not a psychological structure inside us, but actions that happen in speaking, and in this way the human consciousness is

generated (Stiles, 2002). All our experiences leave a sign in our body, but only a minimal part of these ever become formulated into spoken narratives. In formulating these into words they become voices of our lives. When experiences are formulated into words, they are no longer unconscious (Bakhtin, 1984). Also Stern (2004) sees it as more accurate to speak about being non-conscious instead of an unconsciousness into which those experiences and emotions that we cannot deal with are repressed.

There is not only one form of polyphony, but words that are spoken openly and in inner dialogue mean different things for our therapy session. Psychologist Kauko Haarakangas (1997) described horizontal and vertical polyphony. The horizontal level of the polyphony includes all those present as embodied human beings in the conversation. A kind of conversation community is generated. Everyone has their own voice and if we want to mobilise the psychological resources of each one present, everyone should have the right to utter them in their own way.

The vertical polyphony includes all the voices a single participant has in the horizontal dialogue. All relations are, in a way, voices of us, which become active participants in speaking of themes that refer to those relations or experiences. For instance, when a person speaks about the memory of their father, all the voices and experiences related to him become voices in the dialogue for all the participants.

A First Polyphonic Case Example: Pekka's Father

As an example, Pekka was referred to psychotherapy for his deep depression that had led to a severe suicide attempt. His wife and two adult sons were present. The richness of the family therapy conversation becomes evident if we focus on those voices that are not seen but are present in each person's inner dialogues. These voices of the vertical polyphony become 'switched on' depending on the themes of the dialogues. In this case, Pekka was preoccupied by his job as a doctor and difficulties taking care of his duties. He was also preoccupied by his marital problems, by being a father to his two sons and especially by his own father. The memory of his father was actualised when, after a long break in their relations, Pekka took an initiative to re-start the relationship and the father answered yes, but died soon after. Father's voice was invited to the dialogue in the first session.

> T: When did father die?
>
> M: It was 4 years ago.
>
> T: If he … if the father could hear what we are talking about, what would he say or what kind of advice would he give in a situation like this?
>
> M: Well … yes … I am sure that Dad … Dad would be quite sad about this. He would surely show his compassion and …
>
> T: What would he … how would he show his compassion? What would he say, what words would he use?
>
> M: Well, he … he was a kind of a old folk man who could not show everything …
>
> T: Hmm ….
>
> M: … he would for sure try to encourage me …
>
> T: Yes.

M: … and I think that he would handle this quite nice. That's all I can say.

T: But what you think is that he would encourage you and he would show his compassion … and … that … or this is what I hear, that he would in a way understand this situation?

M: Yes. I was the only one of us who could handle father, after he was …

T :   Yes … yes

M: … old …

T: … that he would encourage you and show his compassion. … What do you think your mother would say, if she still could be with us here?

Important aspects of the polyphony are the voices of each therapist. Therapists participate in the dialogue in the voices of their professional expertise, being a doctor, psychologist, having training as family therapists and so on (see Rober, 2005). In addition to the professional voices, therapists participate in the dialogue in their personal, intimate voices. If a therapist has experienced the loss of someone near to her, these voices of loss and sadness become a part of the polyphony. Not in the sense that therapists would speak of their own experiences of death, but in the way they adapt themselves to the present moment: how they sit, how they look at the other speakers, how they change their intonation and so on. Inner voices become a part of the present moment, not so much of the stories told. Therapists' inner voices of their own personal and intimate experiences become a powerful part of the joint dance of dialogue.

Second Polyphonic Case Example: The Silent, Curing Moment

Mary was a sister of Matt, who had a long history of being hospitalised because of schizophrenia. Mary wanted to have family meetings because their history was unspoken. Mary, Matt and their mother Susan came to see us. They said that their tragedy started decades ago when their father died suddenly. Her big brother Matt became very important for Mary when she was 10 years of age, but very soon he discontinued school, started to isolate from friends and the family, and used drugs that caused extreme unpredictable outbursts that became a nightmare for Mary. She was terrified and traumatised when her brother became psychotic, step by step. At the time, Mary was never invited to any family meetings, and not even her mother could explain what was happening with Matt. After being hospitalised for the first time at 18 years of age, Matt had been in the hospital for about 25 years when we met for the first time.

   From the very beginning the dialogues were sensitive in many respects. First, the mother announced that she did not want a family meeting, because she was afraid that speaking about old and sensitive memories would make Matt become psychotic. Indeed, while speaking about some emotionally loaded issue, Matt all of a sudden did start to speak about his specific stories, which could be seen as psychotic. When this happened, I asked him if I had said something wrong for him to speak about those issues. And then I asked if it was possible to go on with the subject we had opened with. Mostly Matt answered that we did not say anything

wrong and allowed us to go further. Step by step, Matt's psychotic speak episodes decreased and on the whole stopped.

After meeting for some 2 years, with about four–five sessions every year, the following sequence of dialogue emerged. This was the first time when Mary, in the presence of her family, could find words for her terrifying experiences. M stands for Mary and T1 for the author.

> M: I have not been recognised.
>
> T1: You have not been recognised?
>
> M: Throughout my life I've been excluded from the family. At last I want to get rid of this symbiotic mess.
>
> T1: You said that 'Throughout my life I've been excluded from the family'. Then you said that 'At last I want to get rid of this symbiotic mess'. It sounds like you are saying two things at the same time?
>
> M: … yes … that's what I said … But so far I cannot say anything more about it.
>
> T1: … yeah.

When Mary first said her experience, the therapist repeated her words. This is often very helpful for generating dialogue in emotionally loaded issues. By repeating word for word, the speaker can hear her own words with a slightly different intonation. Bakhtin (1984) talks of the penetrated word, a word that has been penetrated by the *tone* of another's word; such 'a word [is] capable of actively and confidently interfering in the interior dialogue of the other person, helping that person to find his own voice' (p. 242).

This happened in the episode above. When the therapist repeated the words, it was possible for Mary to hear her own words. After repeating the words and saying, 'It sounds like you are saying two things at the same time', there was a silent moment, and during this present moment Mary heard her words by notifying that was the thing she said but cannot find words for. The silence of the therapists seemed also to be very important, since the therapists did not fill this moment with their meaning by giving comments. This was a powerful moment also because Matt and Mary's mother were there to hear the words for the first time.

With Pekka we worked together for 16 months, having most sessions with him alone and with two or three therapists — one of them being a Master's student in psychology. Every second month we met together with his wife. Pekka recovered from depression, but difficulties remained in the marital relation.

With Mary and her family we have met for 5 years, three to five times a year. Everyone has improved both in their personal lives and their interactions with each other. Her brother has not been admitted into hospital during these years and they have learned to speak with each other. He no longer speaks about any psychotic experiences. In our sessions they have started to discuss the father and the memory of his loss; they have become curious about each other and have learned to live as a family after almost 30 years of living in isolation.

Final Reflections

I have described some important steps in my way of arriving at a dialogical way of life in a professional setting. As I said in opening, I feel uneasy to name this as a therapeutic *method*, but at the same time — as seen in the two short psychotherapy episodes — a dialogical way of life refers to a specific emphasis in the conduct of therapeutic conversations. A main message is the powerful outcomes shown in many studies that verify a focus on generating dialogues in multi-actor settings mobilises clients to use their own resources.

After first opening the door to open dialogues in the mid 1980s the focus was almost entirely on the spoken dialogues, including the importance of responding. Lately, however, moving away from the psychiatric context has meant seeing the embodied quality of our polyphonic presence as more important than the narratives told in the sessions. For me this has also meant becoming more interested in the intersubjective quality of human life on the whole. As living persons we are relational beings; we are born into relations and all the relations within which we live become embodied in the structure of our living bodies — which helps us to understand the simplicity of dialogical empowerment. Nothing more is needed than being heard and taken seriously and it is this which generates a dialogical relation. And when — after a crisis — we again return to dialogical relations, the therapeutic task is fulfilled because agency is regained.

Thus the challenge for any kind of psychological help becomes giving up our own aims for change and intervening to produce change in our clients. As professionals we should learn to follow the way of life of our clients and their language — entirely, without preconditions. This is not easy. But this is the challenge for me. In one of the latest attempts to help therapists to do just that we have developed specific dialogical methods for looking at responsive happenings in multi-actor dialogues (Seikkula, Laitila, & Rober, 2011). In the end, learning the dialogical way of professional life is pragmatic work. In this method of dialogical investigations, the aim is to look mainly at the responses, because dialogue is generated in the way we respond to each other.

The paradox of dialogue may be in the simplicity and complexity of it on the whole. It is as easy as life is, but at the same time dialogue is as complicated and difficult as life is. But dialogue is something we cannot escape, it is there as breathing, working, loving, having hobbies, driving car. It is life. As a final voice, Mikhail Bakhtin (1984) noted:

> … authentic human life is the open-ended dialogue. Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds. He invests his entire self in discourse, and this discourse enters into the dialogic fabric of human life, into the world symposium. (p. 293)

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