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Laura Galbusera & Miriam Kyselo

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# The difference that makes the difference: a conceptual analysis of the open dialogue approach

Laura Galbusera  and Miriam Kyselo

Berlin Center for Knowledge Research, Technical University of Berlin, Berlin, Germany

## ABSTRACT

In this paper we focus on the Open Dialogue (OD) approach to acute psychosis with the aim of better understanding and clarifying the principles underlying its efficacy. To do this, we do a conceptual analysis of the OD literature. We introduce the basic principles of the OD approach and focus on the dialogical process, which stands out as a core healing factor of this practice. In particular, we shed light on one element that yields and sustains dialogue: the dialogical therapeutic stance. We systematise and disentangle different descriptions of the dialogical therapeutic stance and derive some of its essential properties. Based on this, we finally propose a clear-cut definition of the dialogical therapeutic stance as comprising two necessary and constitutive aspects: openness and authenticity. We believe that this conceptualisation might usefully inform the OD practice and theory, and eventually contribute to advance research on the treatment of schizophrenia.

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The Open Dialogue (OD) approach developed since the early 1980s in Finnish Western Lapland as a continuation of the Finnish National Schizophrenia Project. This project aimed at looking for more effective ways to address schizophrenia and eventually led to the development of the Need-Adapted approach (Alanen, 1997; Alanen, Lethinen, Rökköläinen, & Aaltonen, 1991). Within this approach, a series of family-centred and community-based clinical programmes ensued, which emphasised the importance of early intervention and a focus on case-specific needs (Seikkula et al., 2006). Following this conviction, the OD approach consists of a radical reorganisation of the treatment system as a whole, thereby integrating different therapy types according to the clients' needs (Seikkula & Arnkil, 2006).

OD promotes a different and new way of conceiving psychiatric care. Treatment is not aimed at a straightforward elimination of symptoms but, first of all, at understanding their meaning. In contrast to biological psychiatry, the OD approach does not view psychiatric disorders as brain diseases but considers instead each symptom of a person's psychological distress as an adaptive and meaningful reaction to a specific difficult life situation or context (Seikkula, Alakare, & Aaltonen, 2001a, 2001b). Through dialogical processes with clients and their social networks, OD professionals aim at generating new meanings and at finding alternative solutions. The treatment of choice is thus psychotherapeutic, whereas pharmacological therapy is used only in extreme cases.

Studies on the efficacy of OD treatment have shown stunning results: around 80% of patients recovered from schizophrenia spectrum disorders and could return to full-time employment or study. Only 33% of these patients made use of antipsychotic medication during the treatment period. The positive

results were shown to be stable over the long term and the incidence of schizophrenia diminished in the OD psychiatric catchment area (Aaltonen, Seikkula, & Lehtinen, 2011; Bergström et al., 2017; Seikkula, Alakare, & Aaltonen, 2011; Seikkula & Olson, 2003; Seikkula et al., 2001b, 2006). It is important to specify that these outcomes are limited to only relatively small populations and they will need to be confirmed by more robust trials. However, we believe that they already provide sufficient evidence for an important and encouraging path to be followed in schizophrenia research and treatment. Inspired by the promising outcome results of the OD approach, we would like to shed light on possible reasons for them. We thus aim to better understand the principles underlying the efficacy of OD.

The paper is structured as follows. First, we briefly introduce the core principles of OD. In particular, we focus on the dialogical process of OD, which stands out as playing a crucial role for the healing process. We then centre on the dialogical stance of the therapist and clarify what we suggest are its constitutive aspects. Finally, we propose a clear-cut definition of a dialogical therapeutic stance within this clinical context.

## The OD basic principles

The OD approach is based on seven basic principles, which can be differentiated into two levels. The first five principles refer to the macrolevel of the OD system's general organisation and the last two principles to the microlevel of the therapeutic process during the treatment meetings (Olson, Seikkula, & Ziedonis, 2014; Seikkula & Olson, 2003; Seikkula & Trimble, 2005). We begin with the organisational and structural level of the treatment system. The first principle is *immediate help* for the client. A 24-h crisis service ensures that the first meeting with the client happens no later than a day after the client first got in touch with the hospital. The second principle is to adopt a *network perspective*: instead of focussing on the client individually, all relevant persons from her life (family members and other close people) are invited to participate in the treatment meetings. Importantly, at these meetings, all decisions are made in the presence of the client and require her agreement. The third principle is *flexibility and mobility*. The treatment meetings are organised according to the clients' particular needs (e.g. with regard to location and frequency of the meetings). *Guaranteeing responsibility* is the fourth principle and it implies that the professionals who were present at the initial meeting also take the responsibility and initiative for organising and planning the future treatment. This is directly related to the next principle *psychological continuity*, which means that the responsibility for the client's health care rests with the same reference professionals for the duration of the whole treatment.

The second level of OD is the contingent interaction with clients and their networks, i.e. the dialogical process of the treatment meetings. The first principle at this level is *dialogue*. Proponents of OD assume that therapeutic change happens through dialogical interactions with the client instead of being steered unidirectionally by professionals. An important element of this dialogical attitude is that all participants are encouraged to tolerate uncertainty about process and outcome of the treatment, instead of trying to predefine and control the situation. *Tolerance of uncertainty* is thus the last basic principle of OD.

The process of dialogue has been described in its multifaceted aspects by the OD proponents and its importance for the healing process has been repeatedly emphasised. In the dialogical process lies one of the keys to why the OD approach has such positive treatment outcomes (Avdi et al., 2015; Olson et al., 2014; Seikkula, 2002b; Seikkula, 2011; Seikkula & Arnkil, 2014; Seikkula & Trimble, 2005; Seikkula et al., 2001b; Trimble, 2002). However, whereas the principles at the organisational level of OD are very specific and clearly described in their clinical application, a clear-cut conceptualisation of the dialogical process is still missing. At the moment we find manifold and heterogeneous descriptions, which reflect the complexity and nuances of dialogical relations. Yet we believe that a more unifying conceptualisation of the dialogical process might facilitate the clinical application of OD. Let us thus begin by describing what is meant by the concept of dialogue in the OD literature and by looking at what in the first place might create and enable it.

## The dialogical process in OD

Drawing on Bakhtin (1984), Seikkula and Trimble (2005) describe dialogue as a mutual act where meaning and understanding is generated in the space between persons. They also follow Buber, who has classically distinguished between I-Thou relationships (subject–subject) and I-It relationships (subject–object). Buber was convinced that dialogue is an intersubjective process, and thus requires subject–subject relations (Buber, 1987). Hence, Seikkula and Trimble (2005) argue that every participant in a treatment situation, professionals and clients, must participate as active subjects (Seikkula & Arnkil, 2006).

Seikkula and Trimble (2005) further emphasise that dialogue is an open-ended process: understanding and meaning are not reached once for all but continuously emerge along the way. For this reason, they urge us to acknowledge that unpredictability and uncertainty are simply part of the treatment process. Uncertainty also means to embrace the idea of a “neither-nor” reality (Seikkula, 2011 referring to Andersen, 2007), a reality that exists through the embodied encounter with the other person, prior to words and expression. Dialogue is thus not only conceived as the linguistic exchange of spoken words but also, and most importantly, as touching upon an embodied and prereflective reality in which the things we live through cannot be always explicitly and linguistically grasped (Olson, Laitila, Rober, & Seikkula, 2012; Seikkula, 2008, 2011; Seikkula & Arnkil, 2006; Seikkula & Trimble, 2005). It follows that dialogue also implies being present in the here-and-now interaction, and being ready to deal with contingencies rather than relying on pre-planned interventions or goals (Arnkil & Seikkula, 2015; Olson et al., 2014).

In summary, the active participation of all subjects, the open-ended and uncertain nature of the process, as well as the embodied dimension of the encounter and the presence in the here-and-now moment are the main important features of the dialogical process. This process is at the core of what is different and innovative in OD and is directly related to its clinical efficacy. Yet our question is: what specific factors make a difference for the emergence of the dialogical process? As Bateson (1972) puts it, what exactly is the difference that makes the difference? Let us therefore now unpack the constitutive aspects of dialogue and consider what creates and enables it in the first place.

What we consider especially interesting in these regards is how OD conceives of the dialogical stance of the psychotherapist. We have described the dialogical process of OD as an interactive dynamical process, in which all participants play an active role. However, we suggest that the therapist has a very special role, namely to (continuously) initiate dialogue and to set up the conditions for dialogue to happen. The therapist’s attitude and responses create and enable different modalities of interaction. Thereby, she can widen or narrow an interactional space for dialogue and participation, which Seikkula and Trimble (2005, referring to Vygotsky, 1970) call a “zone of proximal development”. As for Vygotsky’s (1970) original notion, this interactional space sets the precondition for evolution and change and it is crucial for the emergence of dialogue (Olson et al., 2012; Seikkula & Arnkil, 2014; Seikkula & Trimble, 2005).

Assuming that the therapeutic stance plays a decisive role for enabling dialogue, in the following we discuss different descriptions of the dialogical therapeutic stance as proposed in the OD approach. We thus identify the necessary and sufficient conditions for a dialogical attitude.

## The difference that makes the difference: openness and authenticity

Proponents of the OD approach follow Levinas (1985), in that they assume that we can never fully understand or explain another person (Seikkula & Arnkil, 2006). The fundamental foreignness of the other is seen as a prerequisite for dialogue and at the same time as the reason for why it is necessary (Seikkula & Arnkil, 2014). Our responsibility towards others does therefore consist not so much in understanding them completely but rather in being ready to respond to them (Seikkula, 2011, p. 185; see also Seikkula & Arnkil, 2006; Seikkula, Laitila, & Rober, 2012). As Bakhtin (1986 p. 127) has put it “for the world (and

consequently for the human being) there is nothing more terrible than a lack of response". A certain readiness to respond should therefore be at the basis of a dialogical attitude.

Yet, not every action or utterance counts as a response. An utterance is a response when it is meaningfully related to an utterance or act from the other subject. Response thus implies the idea of relating. It follows that a dialogical stance is a stance of relatedness. However, "responding" or "relating" still seem too general for defining a dialogical stance. Consider for instance a client, who does not agree to the proposed treatment. The clinician might respond by relying on her authority and giving no other choice than to comply with her judgement. This would indeed be a response, i.e. a meaningful relation to the other person's utterance, but still not one that fosters a dialogical relation. The clinician response closes any possible space for participation.

In the literature, proponents of OD emphasise that, for dialogue, a *responsive* response is needed (Olson et al., 2012, 2014; Seikkula, 2011; Seikkula & Arnkil, 2006; Seikkula & Trimble, 2005). Yet, what makes a response responsive? Seikkula and Arnkil (2006; see also Olson et al., 2012) give a hint of what they mean by responsive response by referring to a certain fittedness of utterance and reply. This suggests that a responsive attitude should entail a certain adaptation to the other's utterances. The idea of adaptation is present in many of the OD descriptions of the dialogical process. Consider, for instance, need-adaptedness, which is reflected in the attitude that the professionals assume in every treatment meeting. The team members open up and focus on what is relevant for the client and adapt, through the course of conversation, to the client's language. Seikkula (2011) has also emphasised that a responsive stance implies being open to the other in the embodied encounter. Attentive and respectful listening to each network member is important to ensure that the voices of all participants can enter the dialogical space. This also involves an attitude of acknowledging the other as other and unconditionally accepting and respecting her. Note that for the OD, this applies in the most radical sense, thus also when the client is psychotic and behaves in an apparently nonsensical way (Anderson, 2002; Seikkula & Arnkil, 2006, 2014; Seikkula & Trimble, 2005; Seikkula et al., 2001a).

These descriptions of the dialogical attitude are diverse, yet they also have something in common. Attentive listening, acknowledging and accepting the other, respecting and taking her seriously, adapting one's own utterances and behaviour to the ones of the other person – all this implies a basic attitude of opening up to the other. We thus take the notion of *openness* as an effective encompassing term under which these different descriptions can be subsumed and suggest that openness is the first constitutive aspect of a dialogical therapeutic stance. An attitude of openness creates possibilities and a space for participation and dialogue. The client is invited to step into the interaction and to take an active role in the dialogical process. This actually ensures that the client participates as a subject, which as we emphasised earlier is a necessary condition for dialogue. Yet, is openness also sufficient for enabling dialogue?

We do not think so. There is another important element we need to address. Recall the earlier example of the non-complying client. The clinician might take the client's perspective seriously, listen with respect, acknowledge and adapt to her, thus following the client's needs and wishes. This would be a responsive response, which is based on a stance of openness as we have just suggested. However, in order to ensure a dialogue between subjects, we also need to make sure that the therapist, for all openness in relating to the client, does not disappear now as a subject herself. By being so attentive and open to the client's needs, she might risk falling for instance into a mere mirroring or echoing position. The therapeutic stance involves a dilemma: in order to ensure that the client is treated as a subject, the therapist needs to be attentive and open to her, yet in doing so she also needs to avoid being too attentive or too open. What prevents this from happening?

We notice that this dilemma is actually mirrored in the way discourses about dialogue have been constructed in the field of psychiatry. The dominant discourse of mainstream biological psychiatry is rather monological in its structure and attitude: clients come into this discourse and are mostly passively defined by it. The voices present in the mainstream psychiatric discourse are often only the ones of professionals, who speak and decide for the clients. Alternatives to this psychiatric discourse are usually built in contrast to this monological attitude, but they come with the risk of creating an equally radical

opposite positioning. Anti-psychiatry, for some of its formulations and proposals, may be seen as an example of this (Crossley, 1998). Consider the example of the Kingsley Hall antipsychiatric community, which was based on a notion of schizophrenia as a voyage into inner space. Professionals working within this community were inspired by extreme openness towards the persons' psychotic experiences and supported the psychotic persons through their "inner voyage". Although this revolutionary approach had a positive effect on rethinking mainstream psychiatric practice, the role of mental health professionals was here reduced to an almost spectatorial one (Berlim, Fleck, & Shorter, 2003). In our view, this might create an unwarranted reverse form of monologue, where it is now the professional, who by being attentive and recognising the client, ends up assuming a passive and witnessing stance to her monologue. Being open to the other is therefore not enough for a dialogical attitude: it must take two to dialogue.

In the OD discourses about dialogue have also been constructed in contrast to the monological attitude of mainstream psychiatry, thus often putting much emphasis on aspects of openness such as listening and adapting to clients or such as the client's interactional dominance (see e.g. Olson et al., 2012, 2014; Seikkula, 1995, 2002a, 2002b; Seikkula & Olson, 2003; Seikkula & Trimble, 2005; Trimble, 2002). Yet, OD does not fall into a reverse monological positioning. It is more nuanced than that. There are relational aspects of the OD therapeutic attitude that cannot be subsumed under the notion of openness and that refer to a more active role on the therapist's side. For instance, Seikkula and colleagues describe dialogue as polyphonic, i.e. as holding multiple voices, including also the voice of the "therapist's active inquiry" (Olson et al., 2012, p. 433; Seikkula, 2008; Seikkula & Arnkil, 2006; Seikkula & Olson, 2003; Seikkula et al., 2012). The therapist's voice should be hearable in its own right and not disappear behind the client's one, for instance by completely endorsing her point of view (Olson et al., 2012; Seikkula, 2008). Simply said, professionals are expected to be resonating as fellow human beings (Seikkula & Olson, 2003; Seikkula & Trimble, 2005). Being transparent and sincere has been highlighted as another fundamental principle for the therapist's attitude during the meetings (Homesland, Seikkula, & Hopfenbeck, 2014; Seikkula & Arnkil, 2014). This also means that the therapist can responsibly rely on her role as a professional. Qua being part of the health care system, she plays the role of the therapist and brings her expertise and professional knowledge into the process. The therapist thus does not only express and act upon her personal feelings but also upon her own professional concern and knowledge. She participates as a whole person (Seikkula, 2008; Seikkula & Arnkil, 2006, 2014).

Again, it is possible to find a common principle underlying these different descriptions of the therapist's attitude. We believe that the polyphony of the process, the transparency in communication, the therapist's active enquiry, her personal resonance and professional responsibility can all be seen as aspects of *authenticity*. Bakhtin's (1984) notion of penetrated word helps to explain this idea. Even when literally repeating another person's words, we always add something to it, for instance a particular tone or pitch. A response thus implies something different from what it relates to, i.e. it is penetrated by the respondent's voice. This captures the idea of authenticity as it refers to the person's owning of her voice in the dialogue (Bakhtin, 1984). Authenticity thus means that the person enacting the response expresses her original contribution and through her enactment she also "interferes" with the other (Seikkula, 2011, p. 190). Thereby, she comes to the fore as another subject. The notion of authenticity we here carve out from the OD approach also recalls Rogers (1966) notion of "genuineness" in psychotherapy. This indicates the therapist's being herself during the therapeutic encounter without hiding behind a mask of professionalism. Yet, importantly, for our notion of authenticity we view professionalism as being a part of and not in contrast to the therapist's subjectivity.

We propose authenticity as the other and second constitutive aspect of the dialogical stance. To clarify this point, let us go back to the example of the non-complying client. A responsive response based on both openness and authenticity might play out as follows. The clinician acknowledges the client's motives and listens to her; she expresses her personal and professional concerns and opinion; and yet she also conveys a willingness to question her own position and to find a solution together. In this case, by listening and taking her seriously the therapist invites the client into an open interactional space for participation and dialogue. Yet, by responding authentically she ensures that she also enters

this dialogical space, thus avoiding a reverse monological situation. Listening and acknowledging the other person are not merely about recognising the other in the sense of passive witnessing but about what we might call *with-ness*, the readiness of stepping together into the interaction.

We view authenticity as the missing element that ensures a therapeutic interaction counts as a dialogue in a Buberian sense. It is the natural and necessary counterpart of openness. By being open one recognises the other as an active partner in the interaction and by being authentic one enters the interaction as an active contributing partner oneself. We thus define the dialogical stance as an attitude of openness towards the other and of authenticity. These two aspects are both necessary and sufficient for a definition of the dialogical stance as they represent its twofold structural core.

The twofold and circular structure of openness and authenticity enables an intersubjective process in which both subjects can move and are being moved. Openness implies a certain readiness to “being perturbed” by the other’s self-affirmation, whereas authenticity implies a certain willingness to “perturb” the other with one’s own self-affirmation. This means that the therapist acknowledges and takes the client seriously, thus being affected by her, and at the same time she takes responsibility for her own stance and affirms it, thus also affecting the client. By this circular movement of caring for oneself and for the other, we can ensure therapeutic change is not unidirectional but instead co-evolving, and thus pertaining to the intrinsic transformative nature of dialogue (Seikkula & Arnkil, 2014).

## Conclusion

We focussed on the OD approach because of its positive outcomes and because of its innovative way to conceive psychiatric care. One of its most revolutionary aspects is that treatment mainly consists in the uncertain and yet transformative dialogical process with clients and their networks. In this paper, we have emphasised the importance of the dialogical therapeutic stance for this process and proposed a clear-cut definition of it. Thereby we have put to the forefront two principles: openness and authenticity. Although based on what already entailed in OD, we believe that our conceptual clarification might contribute to a deeper understanding of the OD practice and to its clinical application.

The clinical relevance of this conceptual analysis goes beyond the OD approach. Indeed, the intersubjective stance of openness and authenticity conceptualised in this paper might usefully inform general psychiatric practice. Several authors from different theoretical perspectives have also pointed out the crucial role played by specific aspects of the therapeutic relationship for the healing process in schizophrenia (e.g. Atwood, 2012; Fuchs, 2007; Stanghellini & Lysaker, 2007). We thus need to invest future research efforts in understanding exactly what, how and why is effective at this intersubjective level. With this paper, we hope to contribute a first step in this direction. A better understanding of these relational processes might indeed be an important ingredient for the further development of effective treatment approaches for psychosis.

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## ORCID

Laura Galbusera  <http://orcid.org/0000-0002-0459-2803>

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