



# *Narrative and Open Dialogue: Strangers in the night or easy bedfellows?*

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This paper briefly describes narrative and open dialogue approaches before exploring their shared values, ways of working, their differences and the possibilities for integration. Both authors have extensive experience in using a narrative therapy approach, while Val Jackson, a family and systemic psychotherapist, also uses an open dialogue approach in her work in an early intervention in psychosis service in Yorkshire, UK.

**Keywords:** *open dialogue, narrative therapy, psychosis, early intervention.*

**Key Points:**

1. Open Dialogue and the narrative approach share a social constructionist paradigm and stress the importance of making space for hearing of people's experience.
2. Open Dialogue is a way of organising services so that individuals and families who are experiencing a mental health crisis receive an immediate and consistent response through regular and frequent network meetings with all who are concerned.
3. Open Dialogue emphasises the polyphonic nature of experience and the many inner and outer voices that contribute to our understanding of experience.
4. The narrative approach emphasises how our lives and identities are multi-storied and shaped by cultural and political forces.
5. A narrative approach can offer a more focused way of working with people, one that is able to impact on people's lives even when frequent network meetings are not possible.

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## EARLY INTERVENTION IN PSYCHOSIS

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There are now early intervention in psychosis services throughout England working with 14 to 34 year olds who are having psychotic experiences for the first time. Although the teams take an inclusive approach to the family, very few teams employ family therapists and the majority use a behavioural approach (Fadden, James and Pinfold, 2012), although systemic approaches and integrated models of family intervention are gaining acceptance (Burbach and Stanbridge, 2006).

I (Val Jackson) first heard Jaakko Seikkula describe the Open Dialogue approach in 2003 when he presented a seminar in Yorkshire. For the last ten years, I have been working in an early intervention in psychosis service enthusiastically applying Open Dialogue principles whenever possible. I first described a narrative approach to family intervention in psychosis in 2007 (Jackson and Elks, 2007; Jackson and Gupta, 2010) and frequently seek to combine these two approaches in my work with families. Over the years, I have shared many conversations with narrative therapist, Hugh Fox, about the similarities and differences of the two approaches. Which brings us to the question that this paper explores: Are open dialogue and narrative approaches capable of integration? Before considering this, let us first introduce both approaches.

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## WHAT IS OPEN DIALOGUE?

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Jaakko Seikkula and colleagues developed the Open Dialogue approach (Seikkula et al. 2003, 2006) in Western Lapland in the early 1980s influenced by Tom Andersen's collaborative approach which listens closely to and responds to the spoken word. Open Dialogue is a network approach that has two important elements that contribute to its success:

### (i) A consistent response

First and foremost, it is a way of organising services so that individuals and families who are experiencing a mental health crisis receive a consistent response, one that focuses on a contextual and psychological understanding of the problem, with less emphasis on medical intervention. It is important to emphasise that this is a whole service approach in Tornio, Western Lapland, standard care for *all* mental health crises, and is not dependent on a diagnosis.

The client, their family, friends and important people in their lives come together with a consistent group of professionals, with all decisions being made in network meetings. Network meetings are arranged within 24 hours of the crisis, to which all who are concerned or involved are invited, including other agencies (e.g. addiction services, probation etc). These meetings can be arranged daily for the first two weeks until a sense of safety is achieved and thereafter as required. Clients are not referred between 'specialist' teams during their contact with the integrated service. The network meetings do not replace other therapies but coordinate them in a consistent approach. If other therapies are recommended, either individual or family approaches, then the lead therapist will become a member of the network team.

The same team meets with the network throughout the life of the problem.

### (ii) Shared dialogue/shared history

Secondly, the professional team of two or three therapists (95% of whom have family therapy training) work closely with the client and their network, developing a dialogue and a shared history in order to create a language for experiences that have previously had no words to describe them. Individuals having psychotic experiences frequently tell us there is nothing wrong and are reluctant to participate in more formal therapy. In these situations, it is particularly important to linger, to listen and tolerate uncertainty. The client's network is very important to the development of this dialogue.

A reflecting process is an integral part of this process. During network meetings the team members share their reflections at regular intervals. This process was largely influenced by Tom Andersen's (1987) reflecting team approach but the reflections are also used for the professionals to share their concerns. These might include ideas about safety, the need for medication, and so on. Each professional is encouraged to share their personal views on these matters, views which may differ from those of others in the network. This creates a way for those that are seeking help to recognise the different options available and emphasises the importance of multiple viewpoints in decision making. Seikkula (2008) draws on Bakhtin's concept of polyphony, which emphasises that many voices exist in dialogue, both between us and within us. Honouring polyphony requires acknowledging previously unacknowledged voices.

Seikkula (2011) describes that listening and responding are key to creating an open dialogue:

*"... while many family therapy schools are especially interested in creating specific forms of interviewing, in open dialogue listening and responsively responding becomes more important" (p.183-4).*

Such responses are often embodied rather than spoken. Embodiment in this context refers to a bodily response. In Seikkula's approach, it is the immediate reaction of our body to words we hear; perhaps tears, facial expression, movement towards or away from each other etc, that plays an important part in ensuring a continuous open dialogue:

*'Compared to narrative and solution-focused therapies, in dialogical approaches the therapists' position becomes different. Therapists are no longer interventionists with some pre-planned 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; Seikkula, 2011, p.187).*

To further clarify the differences between a dialogical approach and narrative/solution-focused therapies, Seikkula quotes Lowe:

*'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, Seikkula emphasis).*

Seikkula seems to be implying that the narrative approach is focused on the therapist's planned intervention and as a result is less likely to mobilise the clients' resources. Whether or not narrative practitioners would agree with this description, the importance of the Open Dialogue response to mental health difficulties is clearly demonstrated by the significant reduction in new diagnoses of schizophrenia in the area where Open Dialogue has been practiced for 30 years: from 34 per 100,000 to 2-3 per 100,000 (Seikkula et al, 2006). Open Dialogical approaches are now being used in many other countries, although most projects have taken the principles and adapted the process locally. In Massachusetts, family therapist Mary Olsen has set up an Open Dialogue training program in collaboration with Seikkula alongside an independently run service for clients and their families experiencing psychosis. The Mental Health department of New York City is funding a five year project (the Parachute) for first episode in psychosis services based on similar principles in five of its districts, free to users. The outcomes of both services will be followed with great interest.

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## WHAT IS THE NARRATIVE APPROACH?

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The readers of this journal may be more familiar with narrative approaches to therapy than they are with Open Dialogue. Here we wish to mention some of the ways in which we believe narrative approaches are similar to Open Dialogue and some of the ways that we think they are different.

Like Open Dialogue, the narrative approach stresses the importance of making space for hearing and acknowledging people's experience. Having been developed from within a family therapy approach, narrative therapy also has an emphasis on convening families or other natural systems; although in practice many narrative therapists work primarily one to one.

Whilst Open Dialogue is concerned with mental health problems, narrative therapy is an approach that can be used with a wide range of difficulties, and is not limited to formal therapeutic situations. Michael White (1996) said that he 'made no distinction between therapy and community development' and he was involved in significant pieces of work with communities under pressure, including First Nations People in both Australia and North America (White, 2003).

Whilst both Open Dialogue and narrative approaches give priority to the hearing of experience, narrative proposes a philosophy to explain social experience through the narrative metaphor. It proposes that meaning is arrived at through the stories that people tell and that are told in the cultures in which people find themselves (White and Epston, 1990; White, 1995, 2004). It therefore understands meaning as being arrived at in social and historical contexts. Narrative practitioners on the one hand deconstruct cultural beliefs that construct people's lives as problematic (White, 1992, 1995, 1997, 2000, 2004) and on the other seek to develop a sense of community which will be supporting of preferred meanings (White, 1997, 2004, 2007). These preferred meanings are taken up into preferred storylines, and it is through the rich description of preferred stories that people are enabled to go forward in their lives in ways that fit with whatever it may be that matters to them (White and Epston, 1990, 1995).

Based on these understandings, White (1995) and other practitioners developed myriad conversational practices to help the therapeutic process to proceed more swiftly but which are always secondary to the process of people feeling understood and acknowledged. Other key aspects of narrative practice include:

- the separation of the person from the problem (externalisation);
- seeking to locate problems in discourse;
- linking lives; and
- a focus on skills, competencies, hopes, values.

While initially resisting to name these approaches as a 'school' or 'particular approach', over time White (2007) developed a number of 'maps' of narrative practice, described in his book *Maps of Narrative Practice*. These 'maps' were intended as a contribution to 'an awareness of the diversity of avenues that are available to preferred destinations' (p.5). They were never intended as a true or correct guide to narrative practice. Importantly, they were never intended as pre-determined therapeutic responses. White always emphasised that each conversation was an exciting journey into the unknown.

From our point of view, narrative approaches and Open Dialogue can be seen as overlapping in some parts whilst addressing different issues in others.

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## INTEGRATION OR COMPLEMENTATION?

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I am interested in how the consistent response and the shared dialogue/shared history principles of the Open Dialogue approach can be combined with narrative practices to enable clients and their families to recover from the crisis of psychotic experiences and prevent further harms. To explore these possibilities, I will offer a short vignette of a conversation.

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## HENRY AND HIS FAMILY

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Here is a short transcript of a meeting with a family in their home. I have chosen this example, because I (Val) was moving between dialogical and narrative approaches, hopefully in a seamless manner!

I was invited to meet with a family, along with two workers from the early intervention team (the case coordinator and family link worker). The dominant story offered by the case coordinator was that the parents of the client, Henry, a 27 year old male, would always insist on being present when the worker visited the home, and it was felt that the client did not have a voice of his own. Present in the meeting were myself, the family link worker (named as Kate in transcript below), the client's brother John, and his parents, Freda and Larry. Henry, reluctant to join us initially, came into the room after 30 minutes. All names and other details have been changed to maintain anonymity. The case coordinator was unable to join us.

It was clear from the beginning that the parents were at their wits end and it wouldn't take much for them to ask Henry to leave home permanently. They had tried lots of things to support Henry including sending him to Ireland to stay with a relative. Larry said that things had worsened recently.

The following is a summary of some of the conversation. It is taken from memory as it was not possible to record this meeting.

Val ( to Henry): I thought I heard you say that you are unable to do any anything good in your life, that only bad things will ever happen. Is that what you said?

**Henry:** Yes, I'm being watched all the time, there are cameras and microphones in the walls, and the police are always there.

**Val:** Is this something to do with what you said, that you are unable to do anything good in your life?

**Henry:** (nods)

**Val:** Can you tell me more about this?

**Henry:** It's very distressing, as soon as I go out of the room, they talk about me. They sent me to Ireland, it was part of a plot to get rid of me.

**Val:** How long has this been happening?

**Henry:** Ever since I came out of prison 18 months ago, the last time I was there for 4 years, and it was much worse than the previous two times. It was bad.

**Val:** What was bad about it?

**Henry:** Being separated from my family, I worried about them all the time. I worried about their health. I worried that I was causing them more worry by being in prison.

Prior to this moment, both parents had been talking over Henry, but when I asked 'what was bad' about his prison experience and he explained that it was being separated from his family and his worry for them, his family members all stopped talking and listened carefully to Henry. At this point, I explained Kate and I would like to talk together about what we had heard so far. We offered the following reflections:

**Val:** I heard that Henry was really worried about his family when he was in prison, and this made his time in prison bad. I wonder if this means he really cares about them?

**Henry:** (interrupting) I really love my family (stated loudly!)

**Val:** I also heard that the family are doing their best to help him, but I have a sense that they feel helpless, and don't know what to do next.

**Kate:** Especially as they have a large family and they are trying to support all of them.

**Freda (Mother):** We do care about Henry very much, we just don't know what to do next.

**Larry (Father):** I used to get very angry with him, but then I realised that he was unwell, so I don't get so angry now. I still explode sometimes. He's paranoid, he needs treatment. He needs to be taken away somewhere.

**Val\*\*:** What's it like Larry when you feel like exploding? If you were able to find words for 'exploding' what might they be? Could it be frustration that Henry is saying things that don't

make sense? Or could it be something else, worry perhaps that he is 27 years old and staying at home all the time? Could you tell me a bit more about the exploding?

Before Larry had time to answer, John says:

**John (brother):** I don't get angry with him, I don't react, and he calms down. The way I see it is that he's had some awful things happen to him, and he can't talk about them.

Larry did not respond and remained silent clearly thinking about John's words. The session ended with an agreement to meet in two weeks' time, although Larry had initially said he did not want to participate at all.

While this is an extremely short vignette and it does not convey the longer term contextual considerations of creating a consistent response and shared dialogue/shared history, I hope it provides a glimpse of what might be possible when dialogical and narrative approaches are brought together. In alignment with both approaches, in the meeting with Henry and his family 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. Dialogical questions were only used to clarify the telling, not lead towards differing understandings.

During the session, however, I was very aware that the parents were close to breaking point and that Larry, the father, did not want to be there. I therefore wanted to create a space for forgotten, or absent but implicit (White, 2000) narratives to emerge. In the conversation above, openings to three such implicit narratives emerged:

- the son who loves his family
- the idea that Henry's difficulties might be the result of terrible events
- the possibility that certain values lie behind Larry (the father) 'exploding'

Whilst Seikkula might prefer to remain within a dialogical frame at all times, I felt that it was important to seek ways to create a foundation for continuing dialogue and partnership between family members. 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 a 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. We left the family home with an agreement to meet two weeks later. Perhaps if we knew we would be able to meet again within 24 hours, then a more dialogical approach of listening and acknowledging words would have been enough. I am also aware that from a dialogical perspective, perhaps if I had enabled a longer silence after Larry had spoken of exploding (see Val \*\* in the transcript above), then this may have resulted in Larry finding his own words in a way that would contribute to continuing dialogue. Then again, maybe it would not have.

I would like to emphasise again the importance of an immediate approach to mental health crisis that creates space for all voices including that of psychosis and that ensures a consistent organisational response. This contribution of the Open Dialogue

approach cannot be underestimated. Without this, the individual and their family are disadvantaged and disempowered as the machinery of a medical model takes control through its specialist language and 'treatments'. Premature decision making can destroy the psychological resources of the client and family, particularly when clients may deny the presence of a problem. As Seikkula has demonstrated (Seikkula et al., 2003; Seikkula & Arnkil, 2006), listening and tolerating uncertainty are crucial, especially in the early stages when family members are in crisis feeling hopeless and helpless.

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## CONTINUING EXPLORATIONS

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From our perspective, Open Dialogue and narrative approaches have the potential to be easy bedfellows but they are not to be confused as interchangeable.

Within the context of Open Dialogue meetings, I (Val) will continue to use a narrative scaffolding approach to: create space for unique outcomes to be made visible,

- raise awareness of old and new knowledges,
- generate richer descriptions of the hopes and values of all those involved in the dialogue, and
- contribute to thicker descriptions of preferred accounts of identity.

I hope that this will provide a stronger platform for family members to know how to go on in life. In my experience, using such an integrated approach enables individuals and families to step into preferred accounts of relationships sometimes in the space of a few sessions. This may be particularly relevant when there is less time or structure for the very regular meetings as established in the Open Dialogue approach in Finland.

We hope that an interesting dialogue between these two approaches can continue. And, of course, it is feedback from clients that will guide us.

The client of one family I (Val) worked with described the dialogical approach as 'just chatting'. Mind you, over just five meetings the hopes for his future had changed from despair to excitement. Other clients within dialogue meetings have responded to narrative questions such as:

*What were you hoping to achieve when you did that? or Does that fit with your hopes for future? Now that's a good question, I need to think about that.*

Whether we are using an Open Dialogue approach, narrative practices, or both, we will be guided by Seikkula's aim that our work as professionals ought to be to create contexts in which to further develop families' psychological resources.

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