# Healing Elements of Therapeutic Conversation: Dialogue as an Embodiment of Love

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*From our Bakhtinian perspective, understanding requires an active process of talking and listening. Dialogue is a precondition for positive change in any form of therapy. Using the perspectives of dialogism and neurobiological development, we analyze the basic elements of dialogue, seeking to understand why dialogue becomes a healing experience in a network meeting. From the perspective of therapist as dialogical partner, we examine actions that support dialogue in conversation, shared emotional experience, creation of community, and creation of new shared language. We describe how feelings of love, manifesting powerful mutual emotional attunement in the conversation, signal moments of therapeutic change.*

*Keywords: Dialogue; Healing; Networks*

This article seeks to identify the actions in dialogue that facilitate healing and to explain how they work. A variety of dialogical approaches to family therapy now exist (e.g., Andersen, 1991; Anderson & Goolishian, 1988; Fishbane, 1998; Inger & Inger, 1994; Paré & Lysack, 2004; Penn & Frankfurt, 1994; Tschudi & Reichelt, 2004). The first author helped develop the Open Dialogue approach (Seikkula et al., 1995; Seikkula & Olson, 2003) in Western Lapland, Finland, as an approach to treating psychosis, schizophrenia, and other severe psychiatric crises.

In the Open Dialogue approach, when a person or family in distress seeks help from the mental health system, a team of colleagues are mobilized to meet with the family and concerned members of the family's network as promptly as possible within 24 hours, usually at the family's chosen familiar location. The team remains assigned to the case throughout the treatment process, whether it lasts for months or for years. No conversations or decisions about the case are conducted outside the presence of the network. Evaluation of the current problem, treatment planning, and decisions are all

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made in open meetings that include the patient, his or her social relations, and all relevant authorities. Specific services (e.g., individual psychotherapy, vocational rehabilitation, psychopharmacology, and so on) may be integrated into treatment over the course of time, but the core of the treatment process is the ongoing conversation in treatment meetings among members of the team and network.

In their acute distress, network members often appear stuck in desperate, rigid, constricted ways of understanding and communicating about the problems that absorb them. In treatment meetings, team members solicit contributions from every network member, especially the acutely psychotic patient. Everyone's utterances are listened to carefully and responded to respectfully. Team members support the expression of emotion. They respond transparently and authentically as whole persons. Transparent about being moved by the feelings of network members, the team members' challenge is to tolerate the intense emotional states induced in the meeting. Their conversations among themselves in the presence of the network serve the function of a reflecting team, expanding the network members' possibilities for making sense of their experiences. Particularly in the beginning phase of treatment, decisions are deferred in favor of expanding and extending the conversation, enabling the system to tolerate ambiguity in the context of extreme stress. This makes it possible to entertain new ideas for addressing the troubled situation.

At the beginning, team members are careful to incorporate the familiar language of the network members into their own utterances. As team members respectfully and attentively draw out the words and feelings of each network member, the conversation shifts. As the original network incorporates the team into its membership, new meanings emerge when new shared language starts to emerge between the team and members of the social network. The drama of the process lies not in some brilliant intervention by the professional, but in the emotional exchange among network members, including the professionals, who together construct or restore a caring personal community.

The meetings are organized with as little preplanning as possible. One or more team members lead the meeting. With everyone sitting together in the same room, in the beginning, the professional helpers share the information that they may have about the problem. The leader then offers an open-ended question asking who would like to talk and what would be best to talk about. The form of the questions is not preplanned; on the contrary, through careful attunement to each speaker, the leader generates each next question from the previous answer (e.g., by repeating the answer word for word before asking the question or by incorporating into the language of the next question the language of the previous answer). It is critically important for the process to proceed slowly in order to provide for the rhythm and style of each participant's speech and to assure that each person has a place created in which he or she is invited and supported to have his or her say. As many voices as possible are incorporated into the discussion of each theme as it emerges. Professionals may propose reflective conversation within the team whenever they deem it adequate. After each reflective sequence, network members are invited to comment on what they heard. When the leader proposes to close the meeting, the participants are encouraged to say if there is something they want to add. Each meeting concludes with the leader or leaders summarizing what has been discussed and what decisions have been or should be made.

Several outcome studies (Seikkula, Alakare, & Aaltonen, 2001; Seikkula et al., 2003; Seikkula et al., in press) have demonstrated the utility and effectiveness of the

Open Dialogue approach, especially in psychotic crisis. The Open Dialogue approach is distinguished by its integration of two key elements, the organization of the treatment system and the dialogic process of the meetings. A team of professionals responds immediately to the client and social network, and continues their involvement for as long as needed. This article focuses on the process of the Open Dialogue meeting itself, with its emphasis on supporting ''polyphonic'' engagement between the voices of client, network, and team.

## CASE ILLUSTRATION: FROM FLASHBACKS TO LOVE

This single meeting, to which the first author had been invited to consult about a ''stuck'' treatment system, embodies much of what we seek to explore in the dialogical treatment process. The network meeting was organized for Ingrid, a resident in a sheltered psychiatric residence. Her difficulties had emerged 9 years ago in reaction to an assault that she and her boyfriend had suffered on the street when three men, friends of Ingrid's brother, had tried to rob Ingrid's boyfriend. Ingrid had been injured when she tried to defend her boyfriend. She began to experience flashbacks of the assault and sought psychiatric treatment. Quite soon after the assault, she disconnected from both father and mother, who had earlier divorced. Nothing seemed to help. The flashbacks, in the form of painful nightly dreams, came to invalidate her entire life. Ingrid was a pleasant woman, and everyone eagerly wanted to help her. Two contact nurses were responsible for her treatment and rehabilitation, working in collaboration with other social and health-care professionals.

Early in her career as psychiatric patient, Ingrid's treatment team had tried to organize family meetings, which turned out to be unsuccessful because of the strong emotions involved. After many years of treatment, the team arranged a network meeting to plan for Ingrid's treatment and future. The meeting, led by the first author as consultant, included Ingrid, her current boyfriend (not the one assaulted), her mother and father, her social worker, the two contact nurses, and her doctor. Although invited to the meeting, her brother did not appear.

The consultant asked the team members about their ideas for the meeting. They said that they wanted to reconnect the family relationships and discuss the future. The consultant offered open-ended questions to Ingrid and her family, wondering how they wanted to use the meeting time. Ingrid said that she was very tense and wanted to hear from her parents. They in turn said that they wanted to hear about Ingrid's current life. Her boyfriend accused Ingrid's parents of failing to support her rehabilitation by not being in any contact with her. The meeting was tense; Ingrid and her parents avoided looking directly at each other. Ingrid's mother began to talk about the assault, coming to tears as she spoke of feeling guilt about the event. She said that when she spoke with Ingrid's brother, he blamed Ingrid's boyfriend for what had happened. The consultant moved carefully to ensure that everyone had opportunity to express his or her concerns, aiming to move neither toward conclusions nor toward treatment planning decisions. One of the contact nurses burst into tears as she described her difficulties trying to help Ingrid without any remarkable success. The mood of the meeting became progressively sadder. Ingrid's mother spoke of pining for the daughter she had loved so much when she was a child.

At that moment, after a short period of silence, the consultant asked the family members to allow the professionals to speak with each other while the family listened. In

the ensuing reflective dialogue, the professionals expressed their surprise at seeing how caring and loving the family members were with each other after so many years with no contact. Agreeing with them, the consultant emphasized how difficult it must have been for everyone in the family these last 9 years, knowing of each other's existence but finding it impossible to express to each other how much they wanted to be in touch. The consultant also commented on the strong involvement of the treatment team.

After the reflective dialogue, the consultant asked the family members if they wanted to comment on what they had heard. Ingrid's mother had been listening to the team's conversation in tears. Her father spoke of being moved by the dialogue and was especially touched by their affirmation of the family despite his own feeling that he had not done enough to reconnect. Ingrid's mother said that she loved her daughter very much. From my (JS) perspective as the consultant, I had been tracking verbal and gestural signs of emotional expression throughout the meeting, my own feelings resonating to the feelings in the room. I was moved by Ingrid's mother's expression of love and by the signs that the others in the room were deeply touched by her words. Ingrid and her mother took each other's hand. I proposed that we close the meeting if no one had anything else to add. All agreed.

As we prepared to close, I asked how the meeting had been for everyone. Many had experienced the meeting positively. Ingrid's mother said that she liked it. She had been so afraid of the meeting that she had not been able to sleep the night before, and she had been extremely tense at the beginning. She said to me, ''You made this so easy, because you were so usual, not at all like a professor.'' Only the social worker had negative comments. She was dissatisfied that such strong emotions had been aroused with no concrete decisions being made for how to go on.

In a follow-up 1 year later, Ingrid remembered the meeting well. She said that it was one of the most powerful experiences of her life. She did not have a single flashback for 4 months following the meeting. Although the dreams of the assault occasionally recurred thereafter, she had managed to start vocational school with team support. She was no longer in a relationship with her boyfriend but was in contact with her mother and had visited with her father and his new family. She had met with her brother on one of her visits with her mother. They had had a couple of family meetings with the team as well.

## MAKING SENSE OF THE DIALOGICAL PROCESS OF HEALING

The development of the Open Dialogue approach involved recursive processes among action, observation, research, description, and theory. Practical clinical discoveries, together with the research information, led us to explore theoretical perspectives, which in turn led to changes and refinements of practice, which led us to further search for theory to describe our observations of the effects of these changes and refinements. The dialogue between the Finnish first author and the second author from the United States added further layers to the recursive process. In what follows, we abstract from this complex enterprise the theory that has informed our practice and our observations of the actions that we believe to have been helpful for the networks with whom we have worked. We share our particular perspective on dialogue and explore how dialogic theory can be enriched by ideas from developmental psychology and neurobiology. We use our theoretical lenses to examine the activities that appear to be factors in healing: creation of new, shared language from multivoiced

conversation, shared emotional experience, and creation of community, all of which, we believe, are supported by powerful mutual emotional attunement, an experience that most people would recognize as feelings of love.

### Dialogue as a Condition for Understanding

The ideas of Mikhail Bakhtin (1975, 1984) and Valentin Vološinov (1929/1973) have influenced the Open Dialogue process from its beginnings. Bakhtin understood dialogue as the condition for the emergence of ideas. It is in the particularities of exchanges between persons in the moment that meaning develops, not within either party's head, but rather, in the interpersonal space between them. "Borrowing" words already richly endowed with the meanings that they carry from their history of prior usage, participants in dialogue craft meanings for those words unique to the particular occasion of their use. An utterance derives its meaning as much from the listener as the speaker; for words to have meaning, they require response. This dependence on response for meaning contributes to what Bakhtin calls the "unfinalizability" of dialogue (Holquist, 1981). Meaning is constantly generated and transformed by the intrinsically unpredictable process of response, response to response, followed by further response, in a process that may be interrupted but can never be concluded. The more voices incorporated into a "polyphonic" (Bakhtin, 1984) dialogue, the richer the possibilities for emergent understanding. Thus, team members strive to draw out the voices of every participant in the room. For each theme under discussion, every individual responds to a multiplicity of voices, internally and in relation to others in the room. All these voices are in dialogue with each other. Thus, the aim is not to find one description or explanation. Dialogue is a mutual act, and focusing on dialogue as a form of psychotherapy changes the position of the therapists, who act no longer as interventionists but as participants in a mutual process of uttering and responding. Instead of seeing family or individuals as objects, they become part of subject-subject relations (Bakhtin, 1984).

One way to understand dialogue is to distinguish it from monologue. Bråten (1988) described monologue as seeing the other as passive. Interpersonally, monologue involves silencing the other by domination or by control of the available means of explanation. Intrapsychically, monologue restricts one's internal representation of the other (Bråten's [1992] "Virtual Other") to the position of echoing and ratifying the inner voice of the self. The verbal exchange between a patient and a physician to rule out a heart attack is an example of interpersonal monologic discourse. The physician is guided in her questioning of the patient by a well-established internal map of the pattern of symptoms of a heart attack and a clear set of instructions for action if the diagnosis is confirmed. The patient's responses to the physician are under the control of this monologic discourse. In situations of trauma, discourse tends toward monologue among members of a network affected by the extreme situation. At times, dominant members of the network may impose their single-minded view of the situation onto the others. More often, several competing views struggle to dominate the situation. Although some individual dialogical utterances may emerge, these do not become the main form of conversation. No one is truly responding or listening to the others because each clings doggedly to his or her own understanding. The conversation persists primarily in the monologic domain, which in such situations is maladaptive because the network members' understandings of the situation have

failed to resolve the situation, and no new ideas can emerge if everyone is stuck in monologic mode. Distressed network members are caught in a dilemma: To find their way out of their situation, they must shift into dialogue, but dialogue by its nature is unpredictable and therefore particularly threatening for people struggling with trauma (Kamya & Trimble, 2002). Thus, in the case illustration, both Ingrid and her mother said how afraid they had been before the meeting.

Dialogism shares with other constructivist and social constructionist approaches to therapy the idea that meaning is generated from relational activity. We share the perspective of those postmodern thinkers (e.g., Lannamann, 1998; Pakman, 1995; Shotter & Lannamann, 2002) who emphasize that this relational activity occurs among ''embodied'' persons, those who are both shaped and constrained by the particularities of their physical bodies and contextual influences (e.g., class, race, gender, culture, geography, history). Physical and contextual embodiment affords both possibilities and limits for the collaborative construction of meaning. Dialogue occurs in the concrete, often mundane, particularities of human experience, in what Bakhtin (1984) called the ''once-occurring event of being.'' Thus, as team members solicit the voices of all the participants in the meeting, they are constantly focused on what is taking place in the moment. Without attunement to the immediacy of the moment, the dialogical process can be inhibited. Haarakangas (1997) described a family therapy training situation in which each time the supervisors introduced proposals for new themes for the conversation from behind the one-way mirror, they interrupted tiny germs of dialogue. From the position of neutral observer not sitting in the same room, it is very difficult to understand the comprehensive, embodied shared experience in which therapist and family members are sitting together. Without this experience, words used and heard easily become merely rational description. In a study (Seikkula, 2002), we found that in the first meeting with a severely psychotic patient, if we did not respond immediately to the patient's psychotic utterances or to first tiny signs of the patient's reflection, the possibility for dialogue might be lost, leading to poor treatment outcome.

From Bakhtin's (1975) perspective, ''for the word (and consequently for a human being) there is nothing more terrible than a lack of response'' (p. 127). Respecting the dialogical principle that every utterance calls for a response in order to have meaning, team members strive to answer what is said. Answering does not mean giving an explanation or interpretation, but rather, demonstrating in one's response that one has noticed what has been said, and when possible, opening 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 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 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. By asking for other network members' comments on what has been said, team members help create a multivoiced picture of the event.

In reflective dialogue, carefully directing their comments and their gazes toward each other rather than toward the network members, and commenting to each other

about their observations, team members construct new words in a very concrete fashion. It is as important for team members to engage each other in dialogue about each other's comments as it is to make the comments themselves. The team dialogue affords the network members a more colorful picture of their own situation, and everyone is afforded more possibilities for understanding what is going on.

Although the content of the conversation is of primary importance for the network members, the primary focus for the team members is the way that the content is talked about. More important than any methodological rule is to be present in the moment, adapting their actions to what is taking place at every turn in the dialogue. Every treatment meeting is unique; all the issues addressed in prior meetings gain new meanings in the present moment. They include what we may remember from the earlier dialogues but also include something completely new, experienced for the first time. The team members' task is to open up a space for these new, not previously spoken meanings (Anderson & Goolishian, 1988).

Team members avoid speaking too rapidly or moving toward conclusions. Tolerating a situation in which no ready-made responses or treatment plans are made available enables network members to make use of their own natural psychological resources. As multiple voices join in the sharing of the situation, new possibilities emerge. These possibilities seldom emerge as a single unambiguous response to the question of how to go on. Different network members live in very different, even contradictory, situations, and thus have very different ideas of the problem. Consider a crisis surrounding a mother, father, and son, in which the son, suspected of drug abuse, becomes nearly psychotic. The father may be concerned primarily about the family's reputation among his coworkers and the mother about her son's health, and the young man may protest angrily that he does not need any treatment and that his parents are crazy and should seek treatment for themselves.

## THE SHARED EXPERIENCE OF EMOTION

Committed to responding as fully embodied persons, team members are acutely aware of their own emotions resonating with expressions of emotion in the room. Responding to odd or frightening psychotic speech in the same manner as any other comment offers a ''normalizing discourse,'' making distressing psychotic utterances intelligible as understandable reactions to an extreme life situation in which the patient and her nearest are living. Understanding does not imply dismissal or minimization of the difficulties experienced; the team member's response resonates with the degree of distress and difficulty uttered. Indeed, sometimes team members offer enhanced opportunity for network members to express feelings of hopelessness. This contrasts with a solution-oriented approach in which the therapist tries to find more positive words to construct experience. In the case illustration, it was important that the emotions of the family members connected to the ''not-yet-spoken'' experience—Ingrid's assault—were expressed openly in the meetings in the presence of the most important people in Ingrid's life.

By making it clear that the team will remain involved with the network throughout the treatment, by assuring that all treatment decisions are jointly discussed and decided, by exploring intensely emotional themes in a calm, engaged manner, and by consistently seeking contributions from all the participants, team members provide reassuring predictability about the intervention process. Network members learn that

they can rely on the professionals to help them remain engaged in conversations about difficult and distressing matters that had not been successfully contained in conversation before.

From its beginning, the practice of network therapy has recognized the importance of shared emotional experience for healing (Seikkula et al., 1995; Speck & Attneave, 1973; Van der Velden, Halevy-Martini, Ruhf, & Schoenfeld, 1984). The crisis that moves network members to seek help and conflicts between network members each contribute to the powerful emotional ''loading'' of a meeting. Responding as whole persons, team members' embodied selves manifest that they are moved by the emotions in the room. Their calm, respectful conversational moves are paced to allow full experience and expression of feelings in the meeting. If team members try to move the conversation forward too quickly at such moments, there is a risk that it will take place solely at a rational level. The most difficult and traumatic memories are stored in nonverbal bodily memory (Van der Kolk, 1996). Creating words for these emotions is a fundamentally important activity. For the words to be found, the feelings have to be endured. Employing the power of human relationships to hold powerful emotions, network members are encouraged to sustain intense painful emotions of sadness, helplessness, and hopelessness. A dialogical process is a necessary condition for making this possible. To support dialogical process, team members attend to how feelings are expressed by the many voices of the body: tears in the eye, constriction in the throat, changes in posture, and facial expression. Team members are sensitive to how the body may be so emotionally strained while speaking of extremely difficult issues as to inhibit speaking further, and they respond compassionately to draw forth words at such moments. The experiences that had been stored in the body's memory as symptoms are ''vaporized'' into words.

It has been our experience that the heavier the experiences and emotions lived through together in the meeting, the more favorable the outcome seems to be. Before the meeting, network members may have been struggling with unbearably painful situations and have had difficulty talking with each other about their problems. Thus, they have estranged themselves from each other when they most need each other's support. In the meeting, network members find it possible to live through the severity and hopelessness of the crisis even as they feel their solidarity as family and intimate personal community. These two powerful and distinct emotional currents run through the meeting, amplifying each other recursively. Painful emotions stimulate strong feelings of sharing and belonging together. These feelings of solidarity in turn make it possible to go more deeply into painful feelings, thus engendering stronger feelings of solidarity, and so on. Indeed, it appears that the shift out of rigid and constricted monological discourse into dialogue occurs as if by itself when painful emotions are not treated as dangerous, but instead allowed to flow freely in the room (Trimble, 2000; Tschudi & Reichelt, 2004).

It is important to remember that all the members of the network are struggling with the emotionally loaded incidents and experiences that constitute the crisis, albeit from different positions. Network members may have acted to bring on the crisis, lived through the effects of the crisis, or both. The hallucinations of a patient having psychotic problems may incorporate traumatic events in metaphoric form. Although the symptoms' allusion to the traumatic events may thereby be inaccessible to network members, they themselves may have been affected by those same events, and their own embodied emotional reactions are stimulated. The emotional loading from these

collective interactions and amplifications of emotional states make the network meeting very different from a dialogue between two individuals. The loading seldom manifests as a huge explosion or catharsis. It emerges most often as small surprises that open up new directions for dialogue. By its nature, the emotional exchange occurs in the immediate moment, and the experience cannot be moved as such to another time or place. The outcome of the meeting is experienced more in the embodied comprehensive experiences of the participants than in any explanations offered for problems or decisions made at the end of the meeting. This may be unusual for professionals used to working in a more structured way. This could have been one factor behind the social worker's negative comment after Ingrid's meeting, when she asked for more concrete decisions to be made.

Observing and reflecting on his experience participating in scores of network meetings, the first author began to recognize an emotional process that, when it emerged in a treatment meeting, signaled a shift out of monologic into dialogic discourse and predicted that the meeting would be helpful and productive. Participants' language and bodily gestures would begin to express strong emotions that, in the everyday language used in meetings, could best be described as an experience of love. As in the meeting with Ingrid and her social network, this was not romantic, but rather another kind of loving feeling found in families—absorbing mutual feelings of affection, empathy, concern, nurturance, safety, security, and deep emotional connection. Once the feelings became widely shared throughout the meeting, the experience of relational healing became palpable.

## APPLYING THE LENS OF DEVELOPMENTAL THEORY

Dialogism is not merely a form of communication but an epistemological stand (Markova, 1990). As dialogical actors in treatment meetings, our experiences of action are necessarily informed by responsive dialogical attunement to the particular moment of conversation among embodied selves in a once-occurring event of being. Yet, as we reflect on these experiences, particularly as we strive to make sense of them to our collegial community, we find it useful to draw from a variety of discourses, including modernist scientific discourse, in order to explain them. As we understand postmodern theory, it does not forbid the use of any form of discourse. Rather, it forbids any form of discourse from making exclusive claims to the truth. We recognize that our efforts to explain may invoke theories that do not, ultimately, agree with each other. In so doing, we believe that, just as in the multivoiced discourse of treatment meetings, we are realizing a polyphonic practice from which new understandings will continue to emerge.

The ideas of developmental psychologist Lev Vygotsky (1978; 1934/1986) resonate in many ways with the dialogic ideas of his Soviet-era contemporary and compatriot Mikhail Bakhtin. Vygotsky proposed that language, thought, and mind originate as interpersonal events that become internalized individual processes over the course of development. Vygotsky reinterpreted Piaget's (1923/2002) egocentric speech as the beginning of the internalization of parental speech, thus refashioning Piaget's individual theory into a social one (Bruner, 1985). The child takes on the roles of both parent and child by instructing and commenting on her own actions. As this multivoiced speech becomes fully internalized, it forms the foundation for inner speech, a powerful instrument for the regulation of action and emotional states.

Vygotsky's idea of the ''zone of proximal development'' provides a frame of reference for understanding how the actions of team members support the flow of emotion in treatment meetings. The zone of proximal development is the metaphorical space between the student who strives to learn new skills just beyond the limits of her current ability, and the teacher who, already having mastered those skills, draws the student forth, offering the teacher's skills as a scaffolding to support development of the student's skills. The process is, however, not a one-sided act directed from the more skillful person to the student, but a mutual cooperation in which the one in charge must constantly adapt his or her activity to the learner (Bruner, 1985). In the case of Open Dialogue, it appears that the team members' experienced mastery of strong emotions in meetings provides a secure framework in which network members discover their abilities to sustain conversation about the most difficult of experiences. Although moved by the emotions in the room, team members are still not as fully embedded as network members are. Not having participated in the past events that have shaped the current crisis, they are less vulnerable to being overwhelmed emotionally. They do not share the intensity of the network members' bodily involvement in the feelings in the room. Their experiences with other crises in other networks have shown them that the current crisis can be survived. The particular experience of the team members is embodied in their presence in the room as they radiate calm confidence and compassionate engagement. Demonstrating, with their embodied presence, that it is possible to talk through extremely difficult experiences, they afford feelings of safety that make it possible for network members to venture forth from their monological impasse.

Contemporary developmental psychologists have shown that in the development of the structure of human brain and body, dialogue is a fundamental formative process originating in the first months of life. Vygotsky's idea that the mind originates in relationship resonates with the ideas of Bråten (1988, 1992, 1997a, 1997b), Stern (1974), Siegel (1999), and Trevarthen (1979a, 1979b, 1990, 1992), who describes the infant as engaging in a dialogical relationship with others from the earliest postnatal moment. The infant enters the world fitted to a parent-child environment in which embodied mutual regulation of emotional states develops over the course of maturation into mutual direction of attention to the world of objects, then into mutual attention to signs, and ultimately into mutual understanding of language.

Trevarthen's (1979a) careful observations of parents and infants demonstrate that the original human experience of dialogue emerges in the first few weeks of life, as parent and child engage in an exquisite dance of mutual emotional attunement by means of facial expression, hand gestures, and tones of vocalization. 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. Siegel (1999) described the neurobiological complexity of the mutual influence between mature adult and immature child through processes of alignment, attunement, and resonance. The emotional dialogue between adult and child shapes the ability of the child's nervous system to self-regulate emotional states and prepares the parent-child system for later learning of language, with its seemingly limitless capacity for expanding dialogue.

Vygotsky (1934/1986) argued that psychological life originates from action in social relationships. In early childhood, the parent's voice organizes and regulates the child's behavior. Speaking aloud, the child begins to develop her own control over her behavior, a transitional form of social control. With maturation, this spoken social

speech becomes internalized as the psychological experience of inner speech, which is instrumental for self-regulation of emotion and action. As the child develops further, words become both the objects and the means of more complex higher mental functions (Vygotsky, 1978), which expand the capacity for making meaning. As a network member speaks aloud, the words produced in her vocal cords make it possible for her to hear what she herself is saying. When responses from team and network members show her that her words are accepted and important, she can reflect on their meaning. As the not-yet-said (Anderson & Goolishian, 1988) emerges in the space between speaker and listeners, response by those present makes for an experience of healing, often manifested by the speaker being visibly moved emotionally. The task for the listeners in that moment is to accept the speaker's words entirely, without offering any word at all of interpretation or of alternative perspective. Offering rational explanation at such a moment may lead the speaker to defend her utterance, and the process is inhibited.

We find these ideas from developmental psychology to be useful in understanding a variety of phenomena in dialogic process. The importance of sustaining emotional expression in dialogue is ratified by the role of mutual emotional regulation in the earliest human dialogical relationship. Mutual emotional regulation is fundamentally formative of the relational process that supports the more complex dialogic processes mediated by language. The experience of loving feelings is an indicator that mutual emotional regulation is functioning effectively in a successful meeting. Mutual emotional regulation also appears to be fundamental to supporting the activities in Open Dialogue of constructing new shared language and creating community.

## CREATION OF NEW SHARED LANGUAGE

The activity of constructing new shared language—incorporating the words that network members bring to the meetings and the new words that emerge from dialogue among team and network members—affords a healing alternative to the language of symptoms or of difficult behavior. The team helps cultivate a conversational culture that respects each voice and strives to hear all voices. Essential team actions toward this purpose include the following:

(1) Asking for information in a manner that makes telling the stories as easy as possible and as distressing as possible. This includes using everyday language, pursuing details, and inviting comments on people's responses, thus generating a multivoiced picture of an incident.

(2) Listening intently and compassionately as each speaker takes a turn and making space for every utterance, including those made in psychotic speech. Showing appreciation for the extreme life situations that engender psychotic ideas and feelings of hopelessness.

(3) Conducting reflective dialogue among team members, commenting not only on the network members' utterances but also on each other's utterances about the network members' utterances. This recursive process helps team members, other professionals in the meeting, and network members to tolerate the uncertainty of a situation in which there are no rapid responses for difficult problems and no rapid treatment decisions. By tolerating this uncertainty,

> network members discover in their sharing of the situation the psychological resources for answering the question of how to go on.

After team members have entered the conversation by adapting their utterances to those of the patient and her nearest relations, the network members may in time come to adapt their own words to those of the team. It helps one to understand more when one experiences the other as understanding oneself. If one discovers that one is heard, it may become possible to begin to hear and become curious about others' experiences and opinions. Together, team and network members build up an area of joint language in which they come to agreements about the particular use of words in the situation. This joint language, emerging in the area between the participants in the dialogue, expresses their shared experience of the incidents and the emotions embedded in them.

By listening to the reflective dialogue of team members, network members discover new possibilities for meaning about the situation. Bråten (1997b) described how the nervous system is organized to allow the person to shift fluidly between engagement with the external Actual Other and engagement with the internal Virtual Other. Momentarily relieved of the need to speak in conversation with others in the room, a network member can activate dialogue with her internal Virtual Other as she listens to the words of the team. From her reflective internal dialogues emerge new ways of understanding the problem situation that, as they are then spoken aloud, lead the group dialogue into new, previously undiscovered possibilities.

Just as symptoms are comprehensive, embodied experiences, so is the new language generated through comprehensive, embodied experiences more than by rational explanation. As network members share feelings of togetherness, they begin to give voice to the not-yet-said. Sharing difficult issues may feel threatening if previous attempts have led to painful failure. One learns that starting to be open with one's own experiences often means that others present at the meeting, even the silent ones, themselves become more open and more able to trust in each other and in the belief that difficult issues are possible to handle. As team and network live through the experiences that thus find their way into the room, their shared emotional experience allows the familiar words of network members to be organized into new understandings, stories in which each participant can address his or her own trauma and handle his or her own emotions. It is when the new language captures the original, unexpressed, distressing story and the context from which the symptoms first emerged that the dialogue begins to compensate symptoms. As network members find language for their traumatic experiences, both the situations described and the emotions associated with them become controllable. As seen in Ingrid's case, this process can be powerful. Ingrid did not have any flashback for 4 months after the single meeting, in which it became possible to share the traumatic incident, dissatisfaction with the long treatment process, and strong feelings of guilt and of belonging to each other.

The healing factors that we have already described contribute to the creation of community. Community is sustained and revitalized by collective sharing of powerful feelings, with the reciprocal attunement process drawing forth our most profoundly human relational capacities. Participation in joint language helps define membership in and identity with community. Meanings and feelings intersect in the deep basic human values that constitute the meeting ground between team and network members. Basic human values are central to the culture of any community.

### LOVE AS A MARKER OF MOMENTS OF HEALING

The process of healing and change in Open Dialogue meetings is subtle, embedded in the familiar language of network members as they talk about getting through their lives together. We have learned that by supporting dialogue in the conversation, encouraging free expression of emotion, and facilitating the emergence of new joint language in the community formed for the treatment, we can witness networks discovering what they need to get through extremely difficult and distressing situations and go on. Certain experiences have come to mark for us turning points in the healing process. They include strong collective feelings of sharing and belonging together; emerging expressions of trust; embodied expressions of emotion; feelings of relief of tension experienced as physical relaxation; and, perhaps surprisingly, ourselves becoming involved in strong emotions and evidencing love. Some others might like to call it a deep trust or some other more neutral term. For us, shifting the focus in a network meeting from an intervention to generating dialogue, we also take a step from applying some specific therapeutic method toward more basic human values.

Maturana (1978) wrote, ''the only transcendence of our individual loneliness we can experience arises through the consensual reality that we create with others, that is, through love'' (pp. 62–63). The feelings of love that emerge in us during a network meeting are neither romantic nor erotic. They are our own embodied responses to participation in a shared world of meaning cocreated with people who trust each other and ourselves to be transparent, comprehensive beings with each other. Tschudi and Reichelt (2004), whose use of network conferencing parallels Open Dialogue meetings in many ways, invoke Buber's (1923/1976) ''I-Thou'' relationship, a wholehearted encounter in which one engages with the other with all of oneself. Our highly focused attunement to the words and feelings of network members resonates with the most fundamental of human relationships, a relationship that developmental psychologists now recognize to be truly reciprocal and dialogical from birth. As we become fully absorbed in the profound exchanges of mutual attunement in a network meeting, we access the feelings that hold us together as relational beings and that make us truly human.

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