Australian & New Zealand Journal of Family Therapy

*Australian and New Zealand Journal of Family Therapy* 2019
doi: 10.1002/anzf.1387

# Open Dialogue: Frequently Asked Questions

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Open Dialogue is an approach to working with people and their families experiencing psychosocial distress. Interest in Open Dialogue in Australia has been growing recently, raising questions about its adaption and implementation to local contexts. This article is an attempt to answer some of the frequently asked questions we have encountered in training and discussions about Open Dialogue. We attempt to provide responses to questions of how Open Dialogue is different to what is done already, how it fits with current approaches, how you know if you are doing it, whether it is passive or just about doing reflections, issues about including the social network, and concerns about the evidence base. This article aims to present a variety of viewpoints in relation to these questions and to hopefully further discussions on how Open Dialogue can be implemented and adapted to Australian health care and social care contexts.

**Keywords:** Open Dialogue, family therapy, dialogical practice, frequently asked questions, therapeutic practice, reflective practice

**Key Points**

1. Open Dialogue originates in Finland and has promise as an approach to working with families when there is mental health distress.
2. Open Dialogue is a new approach being applied in an Australian context.
3. Clinicians new to Open Dialogue often have a number of questions and concerns.
4. This article attempts to provide some answers to these frequently asked questions and may help with implementation of the approach.
5. This article hopes to further the discussion on how Open Dialogue is applied and implemented in Australia.

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Open Dialogue is both an approach to organising integrated mental health care services and a psychotherapeutic approach for people, their families, and social networks who are experiencing psychosocial distress. Open Dialogue emphasises a number of principles and key elements that include providing immediate help, involving the social network, flexibility and continuity of the treatment team, and a particular emphasis on the creation of dialogue within network meetings (Olson, Seikkula, & Ziedonis, 2014; Seikkula & Arnkil, 2006). Open Dialogue is a needs-adapted approach to care: treatment is flexible and does not preclude or restrict the use of any other treatments, including, for instance, medication or individual cognitive behaviour therapy. These are perceived as part of a suite of options that the consumer and the network can consider together.

Open Dialogue was gradually developed in Western Lapland in Finland during the 1980s (Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991). With origins in systemic family therapy, Open Dialogue initially emerged as a model for crisis care with people experiencing psychosis (Seikkula, Alakare, & Aaltonen, 2001). Due to its potential as an alternative approach to mental health care, there has been increasing interest in Open Dialogue outside Finland. Over the last two decades, Open Dialogue has been introduced in health care services across Scandinavia, the United Kingdom, Italy, Germany, and the United States (for examples see Brottveit, 2013; Buus et al., 2017; Gordon et al., 2016; Holmesland, 2015; Razzaque & Wood, 2015; Rosen & Stoklosa, 2016). As Open Dialogue expands to settings outside of Finland, there is a need for contextually specific local adaptions of the approach and a need to understand successful implementation strategies, including Australian applications.

In Australia, increasing interest in Open Dialogue culminated in a special issue on dialogical practices in the *Australian and New Zealand Journal of Family Therapy* (see Brown & Mikes-Liu, 2015). Interest continues to grow with various teams implementing dialogical principles and an increasing number of training opportunities. However, many clinicians working in mental health services in Australia have wrestled with the question of how to meet the obligations of the wider organisation while maintaining an alignment with the principles of Open Dialogue (Mikes-Liu, 2015). Introducing Open Dialogue can at times be challenging, particularly for clinicians who are not familiar with dialogical practices and reflecting conversations. In our experiences with practitioners new to Open Dialogue, there tends to be a number of re-occurring questions and concerns raised about the approach, ranging from the broader issues of service implementation and support by management, to concerns about the application of specific techniques. Considering these common concerns, we thought it timely for a discussion of some of the commonly occurring issues we have noticed, when practitioners begin to implement Open Dialogue and practice dialogically as well as possible responses to these issues.

We generated the list of frequently asked questions (FAQs) based on our own wonderings as well as enquiries from trainees and informal discussions about Open Dialogue. We have composed a list of seven questions that cover the range of concerns we commonly encounter. Each response to the FAQs was written as a polyphonic collaboration between two or three of the co-authors, with review and input from all other authors. Our intention is to present a variety of voices in response to each FAQ.

 

The current group of authors comprises academics, researchers, clinicians, supervisors, and trainers in Open Dialogue and dialogical practice from around Sydney and Melbourne. Our responses are naturally subject to our own perceptions of Open Dialogue. We therefore do not claim to be providing the definitive answers to the FAQs (and nor do these responses necessarily reflect the views of all the authors). Instead we hope to further discussions about Open Dialogue and how it may be applied and adapted to an Australian context.

**FAQ 1. Don't we do this already?**

Open Dialogue and dialogical practices can seem familiar to a lot of clinicians. The principles around providing immediate help, including the social network, continuity of care, and flexibility fit with good clinical practice and current recommendations of the recovery-oriented approach to mental health (Australian Health Ministers' Advisory Council, 2013; Mental Health Commission of New South Wales, 2014). Similarly, client-centred, collaborative, and reflective practices are not unfamiliar to many therapists (e.g., Andersen, 1991; Anderson, 1997, 2007; White, 1995). It is therefore not surprising that with Open Dialogue some clinicians can feel like they are 'doing it already.' There are however some differences that differentiate Open Dialogue from other approaches. Firstly, Open Dialogue prioritises the network meeting and the dialogue that is created within it. Secondly, dialogical practices within the network meeting prioritise the creation of dialogue between all participants as equal voices, including clinicians. These points are expanded below.

The network meeting has a unique and central role in the Open Dialogue model of care. The network meeting includes the client, their family and social network, as well as professionals involved in their care. It is a forum for understanding the problems, making plans, and creating dialogue (Haarakangas, Seikkula, Alakare, & Aaltonen, 2007). This situates the client, the different perspectives on the 'problem,' and the concerns within a relational and social context. Furthermore, all treatment decisions are made collaboratively in these meetings and not by the clinical team separately from the network. In practice, clinicians actively and authentically seek the perspectives and contributions of all participants. The different voices of the treating team are not privileged above those of the other network members. This means that clinicians do not merely seek confirmation and adherence to their pre-decided treatment plans, but adapt and modify them in consultation with the network.

Open Dialogue and dialogical practices emphasise the creation of dialogue within network meetings. This is premised on ideas about the centrality of dialogue in human life (Andersen, 1987; Seikkula, 2011; Seikkula & Trimble, 2005). From this perspective, meaning and understanding are considered to emerge from relational processes that engender dialogue. The role of dialogical therapists therefore becomes the creation of dialogue which offers increased possibilities for all in the meeting to find a way to 'go on' (Wittgenstein, 1953, as cited in Shotter, 1996, 2006). In practice, dialogical therapists work to encourage and elicit responses from all network members. This involves allowing sufficient time for each family member to speak and gently encouraging elaboration when necessary. Importantly, therapists do not attempt to find agreement or compromise between the network members, but merely to encourage the voicing and exploration of each unique perspective. Therapists will also make their own contributions to the dialogue. This can include voicing thoughts, images, metaphors, or bodily experiences that have emerged during the conversation, and

which may be of relevance to the network. This focus on creating dialogue in the presence of a multitude of voices and views, rather than strategically creating change, is also a point of difference to most other therapeutic approaches.

Our position is that the principle of dialogism is what best illustrates the unique offering of Open Dialogue and dialogical practices. In the dialogical space that exists between clinicians and families, clinical expertise is seen as only one of the contributions to the dialogue. It is considered as equal to the ideas and opinions of all others in the network. Indeed, to be in dialogue one cannot remain convinced one knows any situation correctly. Rather one has to be open to being influenced by the voices of others (Anderson & Goolishan, 1992; Galbusera & Kyselo, 2018). In this way, the clinicians join the network, 'being with' rather than 'thinking or talking about' the others in the network (Shotter, 2006).

Open Dialogue and dialogical practices comprise both the familiar and unfamiliar, in relation to alternative models of care and therapeutic practices. Yet, we believe that the uniqueness of this approach in working with families in distress is most evident in the creation of the dialogue in the network meeting. Most possibly, it is here that Open Dialogue and dialogical practices are most challenging and most rewarding for both clinicians and families.

**FAQ 2. But what if Open Dialogue doesn't fit with our model of care?**

We address this question in two ways. First, we speak to the ways that Open Dialogue is compatible with a variety of treatment modalities. Second, we discuss the integration of Open Dialogue with pre-existing models of care delivery. In Open Dialogue, the key elements and processes focus on collaboratively co-ordinating the use of various treatment modalities, which, in turn, actively support an integrative approach. The process of integrating Open Dialogue with existing models of care delivery can be a more challenging task, particularly when underlying assumptions and values diverge.

The centrepiece of the Open Dialogue model of care is the network meeting, involving the client's social and professional network (Seikkula, 2003, also see FAQ 6). Using a dialogical style of conversation, one function of the network meeting is joint decision making about treatment (Haarakangas et al., 2007; Seikkula & Trimble, 2005). Treatment planning is flexible and tailored to the needs of the client and involves utilising the experiences of all members of the network, including the person experiencing distress, family members, and health professionals (Gromer, 2012; Olson et al., 2014; Pippo & Aaltonen, 2004; Seikkula et al., 2003). Open Dialogue focusses on facilitating decision making regarding how to use (or not use) various forms of treatment, and the integration of different therapeutic approaches (Olson et al., 2014; Seikkula, 2003; Seikkula et al., 2003). For example, a network may decide that cognitive behaviour therapy or medication is worth trialling, with these approaches delivered alongside network meetings. Network meetings then create regular, ongoing opportunities for reflection and monitoring regarding treatment progress by the network. Open Dialogue therefore includes both a dialogical style of therapy as well as being a way of organising broader mental health treatment services, which can include a range of other approaches depending on the needs and expectations of the client and their network.

The integration of different models of care delivery can be challenging. Different therapeutic models have different values and assumptions. For example, there can be

 

differences in the proposed causes of problems, mechanisms of change, and the respective roles and levels of involvement of clinicians, clients, and families. Difficulties can occur when integrating different models with incongruent values and assumptions, and clinicians may experience discomfort, anxiety, and distress when asked to practice in ways that do not fit with their existing models of practice. Open Dialogue's emphasis on transparency, flexibility, responsiveness, and the dialogical use of the self in sessions, can be a confronting experience for clinicians used to approaches centred around diagnoses and skills-based interventions. In such cases, it is not surprising that Open Dialogue can feel like it does not fit with existing practice.

Services are being urged to move towards recovery-focused and person- and family-centred care delivery that includes the voices of carers and consumers in making decisions about their own lives. Open Dialogue provides opportunities to move towards service models and practices that are recovery-oriented, person-centred, transparent, and which share responsibility for decision making with consumers and families whilst augmenting and maintaining valuable aspects of existing service delivery models.

**FAQ 3. How do you know what you are doing is Open Dialogue?**

This simple and not uncommon question about what one does in Open Dialogue invites a complex response. Seikkula (2011) asks if dialogical practice is 'psychotherapy' or a 'way of life' (p. 179). A distinction between *doing* (psychotherapy) and *being* suggests that our question might be reformulated as, 'how do you know that you are *being* dialogical?' Open Dialogue originated in the latter part of the 20th century within a specific cultural, social, and political context. While learning and adaptation are relevant to contemporary efforts to *do* Open Dialogue, it would be erroneous to assume that all practices can simply be transplanted into another setting. Therefore, it is important that dialogical therapists are aware of different therapeutic practices, but also responsive and adaptable to the specific needs of the setting they work in and the network they are working with. A continuous process of seeking feedback from the family and reflective practice is one way that therapists can *be* dialogical.

The principles of Open Dialogue may contribute to the dialogical quality of the clinical encounter. Of these, a social network perspective, tolerance of uncertainty, and dialogism guide therapists in the doing and being of Open Dialogue. In contrast, other principles have a bearing on the way Open Dialogue is operationalised. Consider, for example, the timeliness of a response, the navigability of the service for the person and their family, the capacity to engage with social and professional networks, the role of the clinical team longitudinally, and the physical space in which meetings are conducted (Seikkula & Arnkil, 2006). These 'operational' principles can provide a concrete way of knowing that one is *doing* Open Dialogue. For example, is the family seen within 24 hours of referral? Have the family and broader network been invited to network meetings? Do the same members of the treatment team follow the family through their time with the service and facilitate any transitions, such as hospital admissions or referrals?

The social network perspective in Open Dialogue sees the person at the centre of concern as connected to a social network whose influence, if not direct presence, contributes to the meeting. Inviting voices to be heard in the room and noticing the voices that contribute to one's inner conversation reflect a dialogical stance. Therapists' reflections give a considered voice to their own inner conversation, which may

be cognitive but certainly also include affective and embodied responses (Rober, 2005, 2008). In practice, this means that therapists ask questions not only of network members but also of themselves. These questions aim to promote a deeper understanding of one's responses and inner voices. Such questions can include: What thoughts, images, and feelings arise in reaction to this conversation? What physical sensations are present? What memories or associations are connected to these feelings? Which responses are appropriate to share in this dialogue?

Therapists exercise caution in interpreting or directing the session despite the definitiveness and comfort that such strategies can bring. Rather, an emphasis on the present moment requires openness to not knowing how an utterance will be responded to or how the meeting will generate responses outside of the session. Therapists therefore need to monitor their internal responses for urges to direct the session in a particular direction. At these times, it may be helpful to consider the reasons for these desires. For example, in what direction do I want this session to go? Will this direction open or close opportunities for further dialogue? Will one perspective be silenced? Am I responding to the needs of the network or my own needs? Do I have an urge to 'fix' this situation? Acknowledging the unfinalisability of dialogue (Rober, 2005) may assist the clinician to avoid the temptation to view a preferred understanding or action plan as absolute.

A simple and possibly unfinalisable answer to this complex FAQ then is that you may be doing Open Dialogue if you: are sensitive to power dynamics; are curious and uncertain about what emerges from the present moment; invite participant voices (including inner voices) to be heard without the compulsion to reconcile differences; draw on personal and professional resources in your reflections; offer reflections in response and invite the response of others. Doing Open Dialogue contributes to a values orientation that respects the quality of being of all participants in each moment and brings Buberian qualities of 'I and Thou' to each conversation (Buber, 1996).

**FAQ 4. Is Open Dialogue just about being passive and not saying anything?**

Open Dialogue meetings can contain long pauses and silences, sometimes making participants feel uncomfortable and giving the impression that therapists are passive observers who are not allowed to say anything. Silences are sometimes experienced as awkward or excruciating because people often feel compelled to automatically fill them rather than sit with them. However, silences can create very active 'dialogical' spaces. Resisting the intuitive inclination to immediately respond to silence can assist participants to gain understandings of each other and express their personal experiences more clearly. Silences can be viewed as a sign that verbal communication has been successfully slowed down, providing the opportunity to open up and facilitate deeper, embodied reflection in participants.

Everyday conversation usually involves rapid and repeated back and forth turn-taking structure. People closely monitor the other person's talk to project its completion and provide a response with a minimal gap (Sacks, Schegloff, & Jefferson, 1974). As a result, we attend to the external conversation, or the outer voices, and devote less attention to how we are thinking, feeling, and responding internally. In other words, we may pay less attention to our inner voices. In silence, inner experiences can be noticed, and in combination with open-ended and circular questions, silence can provide participants with space to listen to and reflect on their own (inner and outer) and others' (outer) voices. Voices and utterances can reverberate in silences

 

allowing participants to notice what deeply resonates in them; what ideas and feelings have been stimulated in the conversation. Dialogical therapists can therefore ask questions to encourage thinking about inner voices and responses (see FAQ 3 above), and also slow down the conversation to allow time for silences and reflection.

Therapists may experience the discomfort of conversational silence and feel an inclination to alleviate personal or group anxiety by breaking the silence to suggest ways to 'fix problems.' As much as possible, dialogical therapists actively resist invitations to intervene prematurely, and may instead choose to hold the discomfort and open up a reflective space (Schriver, Buus, & Rossen, 2019). Implicit in the therapist's hesitation is a belief that possible solutions may emerge in the dialogues between participants. Saying less rather than more illustrates how therapists de-emphasise professional knowledge so that it does not overshadow the personhood of the client and their network (Mikes-Liu, 2015). When therapists position themselves as learners, space opens up for the client to have a fuller presence, and the network is encouraged to take up an active and engaged position (Anderson, 2005; DeFehr et al., 2012).

Therapists aspire not to take control of the conversational content, but to transparently orchestrate dialogical interactions that emphasise giving each participant the opportunity to speak and the chance to respond. The interactional structuring is polite and tentative, and thoughts, ideas, and experiences of network members are made explicit and accessible to each other (Seikkula & Olson, 2003). Therapists attempt to gently respond to all utterances and to stay close to the language that is used by the participants. This includes nodding, repeating a word or phrase, or stating they heard something that was said in the conversation. This usually helps all participants to feel heard and responded to and acknowledges their experiences through their own words. Therapists work to bring the conversation into the present moment and to maintain a strong relational focus. This can involve the use of questions about how people are responding in the present and how others are responding and thinking. Additionally, therapists also offer reflections, which are personal (re-)articulations of their inner dialogues and responses to what was said in the preceding conversation. Unobtrusively facilitating dialogue, and being authentically responsive in realtime requires the therapist to be considerably active (Galbusera & Kyselo, 2018).

The silences and gentle explorations of participants' voices in Open Dialogue can be misleading, with therapists appearing to hold a passive position. However, therapists are often humbled by the conversations that emerge from silences and awkward pauses, that they resist the temptation to step into. Dialogical therapists aim to actively create spaces for the not-yet-said to emerge in the dialogue between people who care for and know each other best (Anderson & Goolishan, 1988).

#### FAQ 5. Is Open Dialogue just about doing reflections?

The dialogic process in Open Dialogue involves a way of approaching therapeutic conversations, which allows each participant in the meeting to feel heard and responded to. The use of reflections is an important process that is often embedded in the approach, but it does not define the approach. The therapist's stance facilitates a certain way of listening and responding, which invites all voices to be heard, recognising that meaning is constructed through the seeing, hearing, and feeling of all those present (see FAQ 3 above). It is a skill that can be learned, requiring the active attention of the therapist and deliberate practice (Ericsson, 2008), particularly in the key elements that constitute dialogical practice (Olson et al., 2014).

The dialogical space that may emerge from this dialogical process is safe enough to hold all conversations, best enables dialogue, and may engender new ways to go on. It is characterised by the qualities of safety, being with, the present moment, a curiosity and openness to what may emerge (often surprisingly), and being human. Everyone in the meeting plays a part in creating it, by listening openly to the position of others and responding from their own position. This includes repeating or reflecting on words that we 'see' as important to people (also see FAQ 4 above). This process occurs moment-to-moment though verbal and embodied responses.

The reflecting process can take a variety of forms. Andersen's (1987) innovation on the reflecting team was that instead of the clinicians talking about the family in private and delivering their feedback through the interviewing clinician (Watzlawick, Weakland, & Fisch, 1974), the family could observe the clinicians' discussion from behind a screen. Open Dialogue has further developed the technique through the use of reflections in the same room without the use of a screen, and at multiple points in the session as it is felt necessary, rather than at one time towards the end of the session.

Reflection is a process during network meetings where clinicians turn to each other and speak about their personal responses and the inner voices that have arisen during the conversation so far – if they judge it could be helpful for the other participants to hear. Reflections might therefore be understood as a particular way that therapists come 'out in the open' regarding how they see and hear and feel about what has been said in the talk of the meeting. For example, therapists may speak about a feeling of unease, sadness, or joy that they experienced listening to the family. They may also speak about particular thoughts or images that have come to mind. Reflections are voiced as tentative ideas open for discussion rather than firm truths. During these reflections the network listen without responding, focusing on their own inner dialogues. Reflections model a search for understanding and an exploration of differing views, in which meaning may emerge *between* people. When some or all of those in the meeting are open to this process, reflections are more likely to be experienced as flexible and natural, rather than rigid, unnatural, weird, or bothersome to the therapist and/or family members.

The reflecting process should be explained to the family at the beginning of each session and permission asked of them before each reflection. Reflections may occur at any point in the meeting, aiming to open conversation (not shut it down). They can take the form of each individual responding from their inner conversation and are always tentative and spoken from a place of curiosity and wondering. During reflections, therapists may turn their chairs to reflect with each other or simply turn their gaze towards each other, according to what feels most comfortable.

Reflections are only one practice utilised in dialogical meetings. Clinicians also respond moment-to-moment, both with their words and their embodied actions taking a dialogical stance and following a dialogical process. The creation of dialogue is a process to which all present contribute, at each moment. So, while reflections are an important part of this process, they are only one way that therapists can be present and dialogical.

**FAQ 6. Is Open Dialogue suitable for clients with no social network?**

Dialogical therapists contest the idea that anyone has no social network. Therapists are motivated by a conviction that connection, re-connection, and strengthening of

social relationships can generate multiple unanticipated psychosocial resources. Social networks, the important people in a person's life, are seen as a resource of understanding and support, which offer a space to construct and maintain a sense of identity (Seikkula & Arnkil, 2017). Rather than assuming clients have no social networks, thereby closing down opportunities for human connection, dialogical therapists collaboratively and creatively explore the possible relational resources in a client's life. This emphasis on social connectedness is reflected in most of the activities of an Open Dialogue approach, including inviting people to collaborate, open group meetings, reflecting teams, and circular/relational questioning.

Social networks are considered to incorporate both the personal (a client's family and friends) and professional (e.g., teachers, school counsellors, healthcare professionals, and social services representatives). Therapists and clients grow their understandings of these networks together (Seikkula & Arnkil, 2017). In doing so, therapists aim to strike a balance between putting the client at the centre of the dialogue and keeping in mind their social and relational context. Creative and flexible consideration of who comprises the network is important and might start with a client imagining possible connections, and a therapist assisting them to identify who is involved in their story/history and who the people around them are. This may include formal or informal participants in the client's day-to-day life, as well as those who are not necessarily close to or consistently active in the client's life, but hold a place of meaning for the client. A therapist may ask 'who might be concerned about this situation?' or 'who has been involved?,' 'who is important to you?' or 'who might be important to invite to this meeting?'

Inclusion of family and other network members from the beginning is valued, as they can become important partners in treatment/therapy processes. However, there is flexibility based on the client's willingness to have particular people present, and network members' willingness to participate (Olson et al., 2014). Some network members may be infrequently present, or absent altogether, because of competing priorities, geographical distance, or relational conflict. However, social networks are not limited to those who are emotionally or physically close to the client, and not all network members need to attend meetings. Dialogical therapists strive to explicitly involve absent network members in talk and thinking during meetings and may use hypothetical questions for clients to imagine conversations with important or relevant people in their life who are not currently present. In this way, the voices of important others become part of the external dialogue and the client's inner voices may be subject to different examinations and reflections (Olson et al., 2014).

If possible, clients should identify who they wish to participate in network meetings. As concerns change over time, so does the importance of different people in their lives. Therapists should therefore assist clients to continually revisit how they construct their social networks.

**FAQ 7. Why should we do Open Dialogue, there doesn't seem to be any evidence for it?**

The remarkable outcomes for psychosis treated with Open Dialogue, reported in the publications coming out of Finland, draw many clinicians. Follow-up of people with first-episode, non-affective psychosis, revealed that after two years 84% of participants had returned to full-time employment and studies (Seikkula, Alakare, & Aaltonen, 2011), while only 33% had used neuroleptic medication (Seikkula et al., 2006). Bergström et al. (2017) reported on long-term use of psychiatric services in Western

Lapland, evaluating the long-term effectiveness of Open Dialogue treatment: data from 65 participants demonstrated that the majority of clients required only one admission or no admission at all; 95% of participants required inpatient treatment for less than 1 year during the entire 10–23-year period of follow-up, and 45% of participants did not receive neuroleptics during the study period.

A review by Freeman, Tribe, Stott, and Pilling (2019) concludes that whilst the evidence is promising, it is of low quality with a lack of methodological rigour and a high risk of bias, and that no strong conclusions with regard to efficacy can be drawn. They highlight problems with variation in models of Open Dialogue, heterogeneous measures, and inconsistent implementation. Open Dialogue has been piloted in a number of other countries, although robust outcome data are not yet available. The review by Freeman et al. (2019) does not include the register linkage cohort study by Buus et al. (2019), which explores young Danes' use of health care and social care services after being provided Open Dialogue. Participants receiving Open Dialogue intervention (n = 503) had more psychiatric outpatient treatments at 1-year follow-up (RR = 1.2, CI: 1.1–1.4) than the comparison group (n = 1509), but not at subsequent follow-ups. Recipients of the intervention had fewer emergency psychiatric treatments (1-year follow-up: RR = 0.2, CI: 0.1–0.5; 10 years follow-up: RR = 0.5, CI: 0.3–0.8). Unlike the Finnish results, there was no significant reduction in the number of psychiatric hospitalisation contacts or treatment days. These findings are encouraging and add to a growing evidence-base about Open Dialogue, but they should not be regarded as solid evidence of its effectiveness.

Researching Open Dialogue using conventional methods (such as randomised controlled trials) is rendered difficult by elements that are inherent in the way of working. The therapeutic stance that is individualised and tailored to the network's needs and is highly dependent on a personal alliance with the therapist does not lend itself to being standardised or manualised for a standard comparison. The manner of working that deemphasises expertise and expert ways of understanding problems does not sit well alongside (and is likely undermined by) symptom checklists and diagnostic interviews. Researchers therefore need to utilise a range of innovative methods in order to appropriately and adequately research Open Dialogue.

However, beyond the evidence (or limited nature thereof), Open Dialogue embodies principles that are increasingly seen as respectful and ethical ways to practice. Open Dialogue proposes being able to utilise any other evidence-based treatments as they suit the needs of the network at the centre of the treatment (see FAQ 2 above). Open Dialogue is client-centred at its core with a focus on the importance of engagement, shared understanding, and decision making. It is focused on involving people's natural social networks, families, or other important allies to help, make meaning, and support. Open Dialogue also asks clinicians to hear and respect everyone's voice, keeping their expertise, but not letting it override and block out the experience of clients and their networks (Steingard, 2019). As such, Open Dialogue, and dialogical practices more broadly, provide a framework for practice that is explicitly connected to underpinning values.

Services in Australia are being encouraged to be more transparent and inclusive of clients and families. If Open Dialogue promotes a more open, inclusive, respectful, and collaborative approach to mental health services that is welcomed and endorsed by clinicians, clients, and families, this is itself a persuasive reason for its introduction.

## Conclusion

Open Dialogue is a relatively recent introduction to mental health services in Australia. Consequently, we are in an exciting time with new clinicians becoming involved and dialogical ideas being applied and adapted across a number of contexts.

Clinicians new to Open Dialogue have tended to raise similar questions about the approach. We hope to have presented a range of responses to some of these FAQs about Open Dialogue. Although these responses reflect a range of views from a variety of authors, they are limited by our experiences based around Melbourne and Sydney. We acknowledge that this discussion could be further broadened through the contributions from those in other areas and settings, as well as through the inclusion of service users, their families, and communities. Furthermore, these views reflect only our current thinking about Open Dialogue, which will inevitably evolve and develop. Hopefully, the application and evolution of Open Dialogue and dialogical practices in Australia will continue to develop with experience and the contributions of new practitioners. Therefore, rather than providing the definitive answers to these FAQs, we instead hope that this article can further the discussion about Open Dialogue and dialogical practices and encourage others to contribute their understandings and manifestations of this promising approach.

## References


Alanen, Y.O., Lehtinen, K., Räkköläinen, V., & Aaltonen, J. (1991). Need-adapted treatment of new schizophrenic patients: Experiences and results of the Turku Project. *Acta Psychiatrica Scandinavica*, *83*(5), 363–372.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*(4), 415–428.

Andersen, T. (1991). *The Reflecting Team: Dialogues and Dialogues About the Dialogues*. New York, NY: Norton.

Anderson, H. (1997). *Conversation, Language and Possibilities: A Postmodern Approach to Therapy*. New York, NY: Basic Books.

Anderson, H. (2005). Myths about "not-knowing". *Family Process*, *44*(4), 497–504.

Anderson, H. (2007). Dialogue: People creating meaning with each other and finding ways to go on, in H. Anderson & D.R. Gehart (Eds.), *Collaborative Therapy: Relationships and Conversations That Make a Difference*. New York, NY: Routledge.

Anderson, H., & Goolishan, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, *27*, 371–393.

Anderson, H., & Goolishan, H. (1992). The client is the expert: A not-knowing approach to therapy, in S. McNamee & K.J. Gergan (Eds.), *Therapy as Social Construction* (pp. 25–39). London: Sage Publications.

Australian Health Ministers' Advisory Council (2013). *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*. Canberra: Department of Health.

Bergström, T., Alakare, B., Aaltonen, J., Maki, P., Kongas-Saviaro, P., Taskila, J.J., & Seikkula, J. (2017). The long-term use of psychiatric services within the Open Dialogue treatment system after first-episode psychosis. *Psychosis*, *9*, 310–321.

Brottveit, Å. (2013). *Nettverksmøter som kommunikative hendelser, kunnskapsproduksjon og sosial strukturering*. Oslo: Universitetet i Oslo.

Brown, J.M., & Mikes-Liu, K. (2015). Special issue: Dialogical practices. *Australian and New Zealand Journal of Family Therapy*, *36*(1), 1–5.

Buber, M. (1996). *I and Thou* (W. Kaufmann, Trans.). New York, NY: Touchstone.

Buus, N., Bikic, A., Jacobsen, E.K., Müller-Nielsen, K., Aagaard, J., & Rossen, C.B. (2017). Adapting and implementing Open Dialogue in the Scandinavian countries: A scoping review. *Issues in Mental Health Nursing*, *38*(5), 1–11.

Buus, N., Kragh Jacobsen, E., Bojesen, A.B., Bikic, A., Müller-Nielsen, K., Aagaard, J., & Erlangsen, A. (2019). The association between Open Dialogue to young Danes in acute psychiatric crisis and their use of health care and social services: A retrospective register-based cohort study. *International Journal of Nursing Studies*, *91*, 119–127.

DeFehr, J., Adan, O., Barros, C., Rodriguez, S., & Wai, S.B. (2012). 'Not-knowing' and 'assumption' in Canadian social services for refugees and immigrants: A conversational inquiry into practitioner stance. *International Journal of Collaborative Practices*, *3*(1), 75–88.

Ericsson, K.A. (2008). Deliberate practice and acquisition of expert performance: A general overview. *Academic Emergency Medicine*, *15*(11), 988–994.

Freeman, A.M., Tribe, R.H., Stott, J.C.H., & Pilling, S. (2019). Open Dialogue: A review of the evidence. *Psychiatric Services*, *70*(1), 45–59.

Galbusera, L., & Kyselo, M. (2018). The difference that makes the difference: A conceptual analysis of the Open Dialogue approach. *Psychosis*, *10*(1), 47–54.

Gordon, C., Gidugu, V., Rogers, E.S., DeRonck, J., & Ziedonis, D. (2016). Adapting Open Dialogue for early-onset psychosis into the U.S. health care environment: A feasibility study. *Psychiatric Services*, *67*(11), 1166–1168.

Gromer, J. (2012). Need-adapted and Open-Dialogue treatments: Empirically supported psychosocial interventions for schizophrenia and other psychotic disorders. *Ethical Human Sciences and Services*, *14*(3), 162–177.

Haarakangas, K., Seikkula, J., Alakare, B., & Aaltonen, J. (2007). Open Dialogue: An approach to psychotherapeutic treatment of psychosis in Northern Finland, in H. Anderson & D.R. Gehart (Eds.), *Collaborative Therapy: Relationships and Conversations That Make a Difference* (pp. 221–233). New York: Routledge.

Holmesland, A.-L. (2015). *Professionals' Experiences with Open Dialogues with Young People's Social Networks – Identity, Role and Teamwork: A Qualitative Study*. Jyväskylä: University of Jyväskylä.

Mental Health Commission of New South Wales (2014). *Living Well: A Strategic Plan for Mental Health in NSW 2014–2024*. Gladesville, NSW: Mental Health Commission of New South Wales.

Mikes-Liu, K. (2015). Is it possible to be a bit dialogical? Exploring how a dialogical perspective might contribute to a psychiatrist's practice in a child and adolescent mental health setting. *Australian and New Zealand Journal of Family Therapy*, *36*, 122–139.

Olson, M., Seikkula, J., & Ziedonis, D. (2014). The key elements of dialogic practice in Open Dialogue. *The University of Massachusetts Medical School*. Retrieved from http://umassmed.edu/psychiatry/globalinitiatives/opendialogue/

Pippo, J., & Aaltonen, J. (2004). Mental health: Integrated network and family-oriented model for co-operation between mental health patients, adult mental health services and social services. *Journal of Clinical Nursing*, *13*, 876–885.

Razzaque, R., & Wood, L. (2015). Open Dialogue and its relevance to the NHS: Opinions of NHS staff and service users. *Community Mental Health Journal*, *51*(8), 931–938.

Rober, P. (2005). Family therapy as a dialogue of living persons: A perspective inspired by Bakhtin, Voloshinov, and Shotter. *Journal of Marital and Family Therapy*, *31*(4), 385–397.

Rober, P. (2008). The therapist's inner conversation in family therapy practice: Struggling with the complexities of therapeutic encounters with families. *Person-Centered & Experiential Psychotherapies*, *7*(4), 245–261.

 

Rosen, K., & Stoklosa, J. (2016). Finland in Boston? Applying Open Dialogue ideals on a psychotic disorders inpatient teaching unit. *Psychiatric Services*, *67*(12), 1283–1285.

Sacks, H., Schegloff, E.A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, *50*(4), 696–735.

Schriver, K.N., Buus, N., & Rossen, C.B. (2019). Reflective practices in Open Dialogue meetings: Reporting and inferential 'my side tellings'. *Journal of Pragmatics*, *146*, 19–31.

Seikkula, J. (2003). Open Dialogue integrates individual and systemic approaches in serious psychiatric crises. *Smith College Studies in Social Work*, *73*(2), 227–245.

Seikkula, J. (2011). Becoming dialogical: Psychotherapy or a way of life? *Australian and New Zealand Journal of Family Therapy*, *32*(3), 179–193.

Seikkula, J., & Arnkil, T.E. (2006). *Dialogical Meetings in Social Networks*. London: Karnac.

Seikkula, J., & Arnkil, T.E. (2017). *Open Dialogues and Anticipations: Respecting Otherness in the Present Moment*. Finland: National Institute for Health and Welfare.

Seikkula, J., & Olson, M. (2003). The Open Dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Process*, *42*, 403–418.

Seikkula, J., & Trimble, D. (2005). Healing elements of therapeutic conversation: Dialogue as an embodiment of love. *Family Process*, *44*(4), 461–475.

Seikkula, J., Alakare, B., & Aaltonen, J. (2001). Open Dialogue in psychosis I: An introduction and case illustration. *Journal of Constructivist Psychology*, *14*, 267–284.

Seikkula, J., Alakare, B., Aaltonen, J., Holma, J., Rasinkangas, A., & Lehtinen, K. (2003). Open Dialogue approach: Treatment principles and preliminary results of a two-year follow-up on first episode schizophrenia. *Ethical Human Sciences and Services*, *5*(3), 163–182.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in Open-Dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, *16*, 214–228.

Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The comprehensive Open-Dialogue approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis*, *3*(3), 192–204.

Shotter, J. (1996). 'Now I can go on:' Wittgenstein and our embodied embeddedness in the 'hurly-burly' of life. *Human Studies*, *19*(4), 385–407.

Shotter, J. (2006). Understanding process from within: An argument for "withness" thinking. *Organization Studies*, *27*, 585–604.

Steingard, S. (2019, 14 January). Open Dialogue: Does the current research data support further investment? [Blog post]. Retrieved from https://www.mentalhealthexcellence.org/open-dialogue-does-the-current-research-data-support-further-investment/

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of Problem Formation and Problem Resolution*. New York, NY: W.W. Norton & Company.

White, M. (1995). *Reflecting Teamwork as Definitional Ceremony Re-authoring Lives: Interviews and Essays*. Adelaide: Dulwich Centre Publications.

 