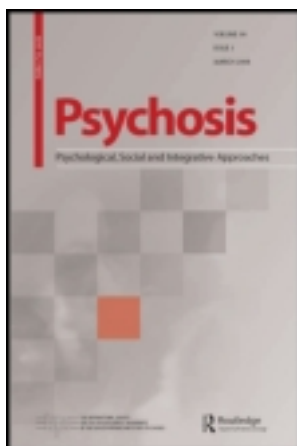


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Publisher: Routledge

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Psychosis

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rpsy20>

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Jukka Aaltonen ^a, Jaakko Seikkula ^a & Klaus Lehtinen ^b

^a Department of Psychology, University of Jyväskylä, Jyväskylä, Finland

^b Division of Psychiatry, Tampere University Hospital, Tampere, Finland

Available online: 12 Aug 2011

To cite this article: Jukka Aaltonen, Jaakko Seikkula & Klaus Lehtinen (2011): The Comprehensive Open-Dialogue Approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states, *Psychosis*, 3:3, 179-191

To link to this article: <http://dx.doi.org/10.1080/17522439.2011.601750>

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The Comprehensive Open-Dialogue Approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states

Jukka Aaltonen^{a*}, Jaakko Seikkula^a and Klaus Lehtinen^b

^a*Department of Psychology, University of Jyväskylä, Jyväskylä, Finland;* ^b*Division of Psychiatry, Tampere University Hospital, Tampere, Finland*

(Received 16 December 2010; final version received 27 June 2011)

Mental health services in a health district in Finland with a population of 72,000 were developed into a comprehensive family- and network-centered entity by giving all the psychiatric personnel training in family therapy or psychodynamic individual therapy, and by arranging a system in which all psychiatric crises were treated in a family- and network-centered manner by multidisciplinary crisis teams, mostly in the patient's home. The system is a modification of the Need-Adapted Approach called the Open-Dialogue Approach (ODA). The changes in the incidence of first-contact non-affective psychoses and prodromal states were studied in two cities of the District, considering the five-year periods before and after the system was fully established. The mean annual incidence of schizophrenia decreased, brief psychotic reactions increased, and the incidence of schizophreniform psychoses and prodromal states did not change. The number of new long-stay schizophrenic hospital patients fell to zero. It can be argued that the ODA has been helpful, at least in moving the commencement of treatment in a less chronic direction. It may have even increased social capital in the entire psychiatric catchment area, and promote mutual trust between the general population and the psychiatric services.

Keywords: Need-Adapted Approach; Open-Dialogue Approach; schizophrenia; first-contact psychosis; family therapy; prodromal states; community based treatment; social capital

Introduction

Since the 1960s, several comprehensive family-centered scientific projects have been carried out in Finland by Yrjö Alanen and his team (JA and KL are members of the team; see the full history and results in Alanen, 1997, 2009; Alanen, Anttinen, Kokkola, Lehtinen et al., 1990). The projects have been aimed at developing a model of treatment for acute psychotic patients and their families. The goal has been to develop a comprehensive, psychotherapeutically oriented model of treatment for (in particular) first-contact schizophrenic patients within the psychiatric public health sector. The model has been called the Need-Adapted Approach. Currently, the approach is being applied and further developed in several Finnish local

*Corresponding author. Email: jukka.aaltonen@jyu.fi

and multi-center projects (Aaltonen, Koffert, Ahonen, & Lehtinen, 2000; Lehtinen, Aaltonen, Koffert, Rääköläinen, & Syvälahti et al., 1996; Lehtinen, Aaltonen, Koffert, Rääköläinen, & Syvälahti, 2000; Seikkula, Aaltonen, Alakare et al., 1995; Seikkula, Alakare, Haarakangas et al., 2006), and also in other Scandinavian countries (Cullberg, 2006; Piippo & Aaltonen, 2004), and in Estonia (Küünarpuu, Küünarpuu, & Saluveer, 2009). Data are being obtained for international comparison (Kalla et al., 2002).

The main principles of the Approach are as follows.

- (1) Therapeutic activities are planned and carried out flexibly and individually in each case, so that they meet the real, changing needs of patients, including the patient's family.
- (2) The treatment is dominated by a psychotherapeutic attitude.
- (3) The various therapeutic activities are designed to supplement each other rather than constitute an "either/or" approach.
- (4) The treatment is set up with the aim of achieving a continuous process and maintaining this process.

The aim of the program described in this article, which is a modification of the Need-Adapted Approach, was to provide family- and network-centered intensive treatment for *all* psychiatric patients (i.e. including first-contact psychotic patients) within a community-based setting, and to develop the entire catchment area according to the principles described above.

In this first article we shall compare the incidences of non-affective psychoses and of patients with prodromal states over two periods, namely before (1985–1989) and during (1990–1994) the full operation of the new system of treatment (the Open Dialogue Approach, or ODA). The second article (Seikkula, Alakare, & Aaltonen, 2011) describes follow-up findings in the 2000s.

The main hypothesis underlying the adoption of the system was as follows: when (1) an open, family- and network-centered approach is applied from the very beginning of treatment in *all* psychiatric crises (not merely psychosis cases), and (2) all staff have received specialist training in family and/or individual therapy, the incidence of schizophrenia-related phenomena, and/or the seriousness of such phenomena, will decrease. We can call this the "impact of wide-spectrum intervention" hypothesis.

Context and materials

Study district

The Western Lapland Health District (population 72,000) is situated to the north of the Gulf of Bothnia, and shares a border with Sweden. The southern part of the district is industrialized, and includes two cities near the Swedish border (Kemi and Tornio) with a combined population of 48,000. Linguistically, ethnically and in terms of religion, the population is homogeneous. Over 90% of the population are Finnish-speaking Lutheran Finns. The treatment system was implemented throughout the area.

As part of the active development of in-patient and out-patient care systems, the number of hospital beds decreased between 1983 and 1992, from 299 to 55 (from 4.2 to 0.8 beds per 1000 inhabitants). During this period, the mean ratio

of psychiatric beds in Finland as a whole decreased from 3.9 to 1.9 per 1000 inhabitants (Tuori, 1994). The number of psychiatric out-patient staff in Finland doubled from 1983 to 1993. In 1993 there were 3.9–8.4 (mean 5.1) psychiatric out-patient staff per 10,000 inhabitants. In Western Lapland the ratio was 5.9, i.e. slightly above the mean. The total psychiatric resources – including hospital beds and out-patient staff – of the District were thus slightly lower than in the rest of Finland.

The District consists of five mental health out-patient clinics plus Keropudas Psychiatric Hospital. There are no other major psychiatric treatment facilities in the area. Cooperation between primary care and psychiatric care is close. This meant that during the study period all psychotic patients and all other, even mild, disorders (Alakare, 2011, personal communication) were referred to the psychiatric out-patient clinics or to the hospital.

The Western Lapland Project

The Western Lapland Project (WLP) has been in progress since 1987. It applies a modification of the Need-Adapted Approach, in cooperation with the Department of Psychology at the University of Jyväskylä and developed in close interaction with Finnish family-centered comprehensive projects, especially the Acute Psychosis – Integrated Treatment Project (API project) (Aaltonen et al., 2000; Lehtinen et al., 1996, 2000; National Board of Health, 1988). The concrete goals of the WLP have been to develop a comprehensive family- and network-centered psychiatric treatment model on the boundary between out-patient and in-patient care systems.

Implementation of the training program

Systematic three-year family therapy training programs were started in 1989 in the Western Lapland psychiatric catchment area. The main theoretical background was systemic family therapy, influenced by the integrating principles of the Need-Adapted Approach and the reflective approach (Andersen, 1987). The training was conducted according to the following principles:

- (1) Culture-syntonicity. A special focus of the training was to tailor it as an integral part of the specific family context of each patient, emphasizing home visits as an essential part of the training.
- (2) Training itself was a continuing process, the aim being that all staff members should receive it, and was conducted entirely as on-the-job training.
- (3) The principal trainers were members of the psychiatric staff (psychologists, psychiatrists, social workers) who had been trained in the family therapy training program arranged by the Finnish Association for Mental Health (JA was leader of the program). As ordinary members of staff, training and supervising peer staff members was only part of their clinical everyday work, a method based on earlier experiences of the Need-Adapted Approach (Aaku, Rasimus, & Alanen, 1980). This meant that in the training process the emphasis was on horizontal aspects of expertise rather than on vertical, authority-emphasizing aspects.

In addition to the family therapy training, a two-year program of training in psychodynamic individual psychotherapy was conducted for those more interested in individual therapy.

By 1995, 90% of the out-patient and in-patient staff had received at least two years of special training: over 70% of the staff underwent the three-years' training in family therapy and 20% two-years' training in psychodynamic individual psychotherapy.

Implementation of the treatment system

The comprehensive family- and network-centered treatment system was developed in three phases.

- (1) *Out-patient unit in the hospital.* As a first step in the ODA, a multi-professional outpatient unit was founded in the hospital at the end of 1987. The team of the unit consists of a psychiatrist, a psychologist, a registered psychiatric nurse and a mental nurse. Its task is to organize the first treatment meeting for all patients referred to the hospital, together with their family members, before a decision about admission is made. All treatment decisions are made in the presence of the family and the patient. The first meeting is held within 24 h of the initial contact.
- (2) *Mobile psychosis teams.* Because the need for hospitalization decreased, the need to take charge of the crisis within the out-patient centers increased. A mobile multi-professional psychosis team was established in 1989 in every psychiatric out-patient center; six teams altogether. The mobility of the team enabled, in particular, home visits and flexible cooperation between in-patient and out-patient units.
- (3) *Case-specific teams.* As a result of the extensive family therapy training, fixed psychosis teams (except for the team of the out-patient unit in the hospital) were discontinued, and the responsibility for arranging a case-specific, multi-professional team was extended in 1990 to every psychiatric staff member, within both out-patient and in-patient care.

The mobile psychosis teams and case-specific teams had, from the beginning, connections with the national multi-center project (API project) (Lehtinen et al., 1996, 2000).

At the beginning of the 1990s, the new system of treatment became established, and is currently in use throughout the District in the treatment of every new case of psychiatric crisis *regardless of the problem or diagnosis*. This also means that psychiatric out-patient centers and hospital wards jointly organize case-specific teams.

As illustrated in a recent film (Mackler et al., 2011), the principles of the ODA are as follows.

- (1) *Immediate help.* The teams arrange the first meeting with the patient, his/her family and other key members of the patient's social network within 24 hours of the first contact made either by the patient, a relative, or a referral agency.
- (2) *Responsibility.* The staff member who is first contacted, irrespective of his or her professional or other working status, is always responsible for arranging

the first meeting. If the question of hospital treatment arises, an admission meeting is arranged by the team in the hospital, either before the decision in the case of voluntary admissions or, in the case of compulsory admission, during the first day of in-patient treatment. At this meeting a case-specific team, consisting of both out-patient and in-patient staff, is assembled. This tailor-made team takes charge of the entire treatment sequence, regardless of whether the treatment is continued in the patient's home, in the out-patient clinic, or in the hospital, and regardless of how long the treatment lasts. New treatment meetings are arranged as often as needed, up to several times weekly, either within out-patient or hospital care.

- (3) *Tolerance of uncertainty.* The task of the staff is not primarily to function as experts providing solutions to the crisis, but, instead, to generate reflective processes (Friedman, 1995) among all participants. In the treatment meetings the case-specific team negotiates with the patient and family members, including about whether individual therapy is needed, according to the principles of the Need-Adapted Approach (see Alanen, 1997, pp. 173–175).
- (4) *Open dialogue.* The focus is not only on illness. The team has to generate open dialogue between all participants (patient, family members, professionals). The aim of the dialogue is to construct a new language for the difficult experiences and for the prenarrative quality of life (Ricoeur, 1991) of the patient and those nearest to him/her in connection with the patient's behavior, and to open up a new understanding and the possibility for a new inner dialogue (Andersen, 1990; Penn & Frankfurt, 1994).
- (5) *Increasing social capital and mutual trust.* According to Hamilton, Ponzoha, Cutler, and Weigel (1989), one of the special features of the psychotic patient's social network is that there are often no persons to whom the patient can lend his or her social support. The emphasis on the mutuality of ODA can develop the patient's abilities to give as well as receive in social relations, and thereby not be experienced only as a patient. At the same time, comprehensive catchment area-wide family-oriented work can increase social capital (Bourdieu, 1986; Hyypä & Mäki, 2003; Putnam, 1993) within the basic population via the increased mutual trust that is engendered between that population and the Need-Adapted treatment system (Piippo & Aaltonen, 2004, 2008a,b).

Methods

Sample

The data in this report relate to all patients aged 15–44 who, for the first time in their lives, came into contact with psychiatric out-patient or in-patient services between 1985 and 1994. The exclusion criteria were an organic cerebral illness and severe mental retardation. The catchment area was the two cities of Kemi and Tornio. The population of these cities remained the same throughout the period. Altogether, 1,918 first-contact psychiatric patients contacted the mental health centers in Kemi and Tornio between the years 1985 and 1994. Out of these, 250 cases (133 in Kemi and 117 in Tornio) were either defined as functional non-affective psychosis, according to DSM-III-R, (American Psychiatric Association, 1987) or showed prodromal symptoms for schizophrenia. Thus 13% of all first-contact

patients were assessed as having either non-affective psychotic problems or as living in a prodromal state (Yung, McGorry, McFarlane et al., 1996). Of these 250 patients, 135 (54.0%) were men and 115 (46.0%) were women. The mean age of the men was 27.9 and of the women 28.0 years. The first-contact psychotic patients were not treated in primary care.

The design of the study was based on a historical control design (McGlashan, 1996), comparing (1) the annual incidences of schizophrenia, other functional non-affective psychoses and patients with prodromal states for schizophrenia in 1990–1994 (experimental program) with (2) similar incidences in 1985–1989 in the same geographical area, i.e. before the introduction of the experimental program.

Two of the authors (JA and JS) read all the case records from (1) the mental health outpatient centers of the two cities, (2) the out-patient unit in the psychiatric hospital, (3) the hospital, and (4) the former central psychiatric hospital of the District, where some of the acute cases, mainly alcoholics, were referred until 1989. The patients were re-diagnosed (DSM-IV-R; American Psychiatric Association, 1994) on the basis of the records. The diagnosis was made according to the initial situation and development of symptoms during the first six months following referral to psychiatric services.

For the purposes of the analysis a list of prodromal symptoms was developed. The list was based on the work of Falloon (1992) and on the prodromal signs outlined in DSM-III-R. The list consists of symptoms of a psychosis-like nature, demanding treatment in themselves; that is at least one of the following symptoms: (1) marked peculiar behavior, (2) inappropriate or loss of affect, (3) vague, rambling speech, (4) marked poverty of speech and thought, (5) preoccupation with odd ideas, (6) ideas of reference, (7) depersonalization or derealization, (8) perceptual disturbances, or (9) odd somatic sensations or fixed ideas. The last one was added, in accordance with Beiser, Erickson, Fleming, and Iacono (1993).

The symptoms of all the patients were in most cases well documented. Treatment processes were described in detail, with discussions with the patient and in-treatment meetings; in many cases even recorded verbatim. In order to sharpen and deepen the diagnostic process and to prepare the data for quantitative research, the first and second authors wrote a “thick” summary description (Denzin, 1978) of every case, concentrating on (1) the emergence of the first prodromal state, (2) the first prominent psychotic symptoms and the onset, (3) the duration and content of the period during which the psychosis had been untreated, (4) patterns of family dynamics, (5) the role of the principles of treatment described earlier in this article, and (6) the outcome after the two-year follow up.

For the final diagnosis the first and second author negotiated a consensus after independently reading all the records and the thick descriptions, and in some cases after re-reading the records. In all unclear cases the researchers interviewed the therapists and other team members.

The first and second authors were the main planners of the project. However, the first author had not worked permanently in the district, did not know the patients beforehand, and did not have any direct clinical responsibilities concerning the patients. His role was that of scientific head and supervisor of the project.

To test reliability, the third author (KL), a totally independent, experienced psychiatrist who had SCAN-2 training (Janca, Ustun, & Sartorius, 1994) in psychiatric diagnostics, and who was blind to the consensus diagnoses, read a randomized sample ($N = 56$; 27 from the period 1985–1989, and 29 from the period 1990–1994) of

the original records. To prevent bias, he was given only the original records for the first six months, with all dates removed. He was not told about the classification of the patients into two periods, and was not given the thick descriptions. We used the kappa coefficient as a measure of diagnostic reliability (Cohen, 1968). The kappa for the entire test was 0.60 ($p < .001$). The consistency of the diagnoses was similar for both periods.

The first two authors diagnosed more schizophrenia cases in both periods – and especially in the second period – than the independent researcher. This indicates an absence of bias towards seeing less schizophrenia (which might have originated from a desire to demonstrate the effectiveness of the new approach), and indicates that the records had not become less diagnosis-oriented. For the final analyses the diagnoses of the first authors were used.

Results

Annual first-ever contacts and incidences

The role of the hospital changed rapidly after the out-patient unit in the hospital started working. During the first full year (1988) of this new activity, out of the total number of patients referred to the hospital by GPs or psychiatric out-patient centers, 40% were not hospitalized (Keränen, 1992); thus the out-patient crisis intervention organized by the unit appeared to be a successful alternative to in-patient care.

The number of new long-stay schizophrenic hospital patients in the District fell to zero in 1992. The mean in Finland was 3.50 per 100,000 inhabitants (Tuori, 1994). No new long-stay schizophrenic hospital patients have since emerged. The term *new long-stay hospital patient* here indicates a person who for the first time in his/her life has been treated as an in-patient for a continuous period of longer than a year (Tuori, 1994; Tuori, Lehtinen, Hakkarainen et al., 1997). It did not, however, mean that patients were treated in other in-patient institutions outside psychiatric treatment.

The 250 first-contact patients consisted of the following groups: schizophrenia ($N = 84$); schizophreniform psychosis ($N = 30$); brief psychotic reactions ($N = 19$); other non-affective psychoses ($N = 22$); patients in prodromal stage ($N = 95$). The highest number of new schizophrenia cases ($N = 15$; incidence per 100,000 total population = 31) and of all schizophrenic disorders (schizophrenia and schizophreniform psychosis $N = 20$; incidence = 46) occurred during the year 1985. The lowest number of new schizophrenia cases ($N = 3$; incidence = 6) and of all schizophrenic disorders ($N = 5$; incidence = 10) occurred during 1994, the last year of the study period. The trend shows a decline throughout the period. For the years 1995 and 1996, the annual number of new schizophrenia patients remained at the same level ($N = 4$). The highest number of new schizophreniform cases ($N = 6$; incidence = 12) occurred at the beginning of the second period; that is, during the first year that the new approach was in operation for the treatment of *all* new psychiatric out-patient and in-patient cases. The number of cases and the mean annual incidences for the periods 1985–1989 and 1990–1994 are shown in Tables 1 and 2.

The incidence of all schizophrenic disorders (schizophrenia and schizophreniform psychoses) significantly decreased (from 73 to 41 patients: from a mean annual incidence of 30.3 to 17.1; $\chi^2 = 7.44$, $d.f. = 1$, $p < 0.01$). However, the decrease in this

Table 1. Mean annual incidences per 100,000 total population (48,000) of schizophrenic psychoses and prodromal states in Kemi and Tornio cities between 1985–1989 and 1990–1994.

Diagnosis	1985–1989 Mean annual incidences N = 139	1990–1994 Mean annual incidences N = 111	Chi square
Schizophrenia	24.5	10.4	13.75***
Schizophreniform psychoses	5.8	6.7	.13
Total schizophrenia and schizophreniform psychoses	30.3	17.1	8.97**
Brief psychotic reactions	1.2	6.7	8.89**
Other non-affective psychoses	5.0	4.2	.18
Prodromals	21.2	18.3	.52

* $p < .05$; ** $p < .01$; *** $p < .001$.

Table 2. Numbers of patients displaying new schizophrenia, schizophreniform psychosis, brief psychotic reactions, other non-affective psychosis, and prodromal states in 1985–1989 compared to 1990–1994.

	1985–1989		1990–1994		Total
	N	%	N	%	
Schizophrenia	59	42.4	25	22.5	84
Schizophreniform psychosis	14	10.1	16	14.4	30
Brief psychotic reaction	3	2.2	16	14.4	19
Other non-affective psychosis	12	8.6	10	9.0	22
Prodromals	51	36.7	44	39.6	95
Total	139	100	111	100	250

Chi-square = 11.02; $p = .004$.

group occurred only in schizophrenia (from 59 to 25 patients: from a mean annual incidence of 24.5 to 10.4; $\chi^2 = 13.75$, $d.f. = 1$, $p < 0.001$). The incidences of the other non-affective psychoses (5.0–4.2) and prodromal state (21.2–18.3) did not change significantly. The incidence of brief psychotic reactions increased (from 3 to 16 patients: from a mean annual incidence of 1.2 to 6.7; $\chi^2 = 8.89$, $d.f. = 1$, $p = 0.025$).

The mean annual number of all first admission patients to the out-patient and in-patient centers (including psychotic, prodromal and non-psychotic cases) increased from 173 to 216, indicating that the decline in the number of psychotic patients was not due to a decline in the total use of psychiatric services.

Discussion

This report has (1) described the comprehensive family- and network-centered system of treatment based on the Open-Dialogue Approach, developed and introduced in Western Lapland, and (2) examined whether the incidence of non-affective psychosis and patients in prodromal states to schizophrenia changed during the new system of treatment.

The main hypothesis was: when open dialogue is emphasized from the very beginning of treatment in all cases (not only in psychotic or psychosis-related cases), and when all staff have received specialist level training in family therapy, the incidence of schizophrenia-related phenomena and/or their seriousness will decrease. We called this the “impact of wide-spectrum intervention” hypothesis. The aim in this was to begin the treatment process with the patient, plus his/her family and social network, in all psychiatric crises *regardless of the problem or diagnosis*. So far, the results give support to the hypothesis.

By 1995 almost all the psychiatric staff were trained psychotherapists. In 1994 the number of psychotherapists was 37 per 100,000 inhabitants. The mean for the rest of Finland was 9 per 100,000 inhabitants (Tuori, 1994). To establish the best possible working conditions for the trained staff, so that they could put their training into practice, the system of treatment was arranged so that mobile, multi-disciplinary case-specific teams (consisting of both out-patient and in-patient staff) were established in the psychiatric hospital, and in all the out-patient centers.

In parallel with this process, the number of new long-stay schizophrenic in-patients fell to zero – the only psychiatric catchment area in Finland in which this occurred (Tuori, 1994).

According to the official statistics issued by the National Research and Development Centre for Welfare and Health (Pelanteri, Lounamaa, Salmela, & Tuori, 1995), in Western Lapland Health District between 1990 and 1993 the mean ratio for the number of in-patient periods per hospitalized patient was 1.6. The mean ratio for the rest of Finland was almost the same, 1.5. The mean hospital stay in the District was the lowest in Finland (30 days; mean for the rest of Finland 49 days). Some 55% of the patients stayed in the hospital for less than 10 days (vs. 32% for the rest of Finland). It is thus not possible that the long-stay hospital patients in the District disappeared as a result of the change in treatment, only to be replaced by shorter but recurrent hospitalizations. Hospitalizations in the District were shorter than elsewhere in Finland; however, this did not lead to more frequent hospitalizations, possibly because the approach helped the patients’ social network to survive.

The mean annual incidence of schizophrenia decreased highly significantly during the period in which the new system of treatment became well-established, in comparison to the previous situation. At the same time, the proportion of schizophrenia cases out of all psychotic problems declined. However, the incidence of schizophreniform psychoses did not change. The major criterion differentiating schizophrenia from schizophreniform disorder, according to DSM-III-R, is: in schizophrenia the psychotic symptoms have been present for six months or more, and in schizophreniform disorder less than six months. Our results raise the question of where the potential schizophrenia patients disappeared to.

It seems clear that fewer psychiatric crises developed into schizophrenia. Because the total number of all first-contact patients did not decrease – i.e. the total use of the psychiatric services did not change – the decrease in schizophrenia cannot be interpreted, for example, as an increase in untreated morbidity. It can thus be argued that the ODA has been helpful – if not in actually preventing schizophrenia, at least in moving the commencement of treatment in a less chronic direction. As shown in our two follow-up studies (Seikkula et al., 2006; Seikkula, Alakare, & Aaltonen, 2011) the results have long-term stability.

A study based on a historical control design has shortcomings, largely due to the lack of a randomized control. Thus, for example, the possibility that other

factors in the treatment system, or beyond, other than the ODA may have contributed to the effects remains open. The results are, however, similar to other projects, where Need-Adapted Approach or its modifications have been implemented to the whole catchment area in Finland (Alanen, 1997; Lehtinen et al., 2000) and in the Parachute Project in Sweden (Cullberg, 2006), suggesting that the change of treatment culture can have a specific effect for the treatment of first-contact psychosis and prodromal state.

Limitations

Another limitation is that we do not know which part out of the whole spectrum of mental disturbances or phenomena is mainly affected by the comprehensive family- and network-centered system of treatment. The system may induce a shift in the total spectrum towards the less-severe end. It is possible that in the early phases, some forms of schizophrenia are especially sensitive to this kind of open dialogue or wide-spectrum relational approach, i.e. an approach which does not focus on the specific pathology.

Nevertheless, why the incidence of prodromal states did not show a significant increase remains an unanswered question. In general, the question of the specificity of early or prodromal state of schizophrenia is unclear and problematic, both conceptually and when actually deployed in a community-based treatment system (Birchwood & Tarrier, 1992; Falloon, 1992; Heinimaa & Larsen, 2002; Johannessen & McGorry, 2010; Kaymaz & van Os, 2010). The importance of healthy communication as a protective factor against, for example, genetic vulnerability to schizophrenia has been demonstrated in Finnish adoption studies (Tienari, Wynne, Morig, et al., 1994; Wahlberg, Wynne, Hakko, & Läksy, 2004; Wynne, Tienari, Nieminen, Sorri et al., 2006). The implication of such findings is that wide-spectrum (not just schizophrenia-related) psychological understanding and treatment of the family environment and communication are indicated, irrespective of the other possible constituents in the etiology of schizophrenia.

An even more problematic finding of the study relates to the decline in the incidence of schizophrenia. In fact, evidence of a general decline in the incidence of schizophrenia is not clear, and there are even contrary findings (Salokangas et al., 2010). According to Der, Gupta, and Murray (1990), the decline in the incidence of schizophrenia could reflect (1) a change in diagnostic habits, (2) a trend toward schizophrenic patients being treated as out-patients, or (3) a real decline in the incidence of schizophrenia.

In our study the possibility of a change in diagnostic habits and a trend toward out-patient treatment was reduced to a minimum by re-reading and re-diagnosing all the in-patient and out-patient records. However, another potential source of bias came from the fact that the re-diagnosing of the cases was done retrospectively and from the case records by the researchers – persons who were themselves involved in the process of developing the system of treatment. With this in mind, in order to study possible bias, a randomized sample of records was assessed by a totally independent skilled researcher, someone who was blind to dates, the main researchers' diagnoses and the outcomes of the treatments. The level of inter-rater reliability indicated that the main researchers were not biased towards defining less schizophrenia during the period when the ODA was introduced for all new cases of crisis, or conversely, more schizophrenia before the ODA.

The District did not go through any remarkable social or demographic changes during the period 1985–1994. The primary health service system did not change; psychiatric private practice did not increase and, in fact, played an insignificant role throughout. The economic depression of the 1990s did not cause changes in migration either in Finland in general or in Western Lapland in particular; hence there are no reasons to suppose that the decline in incidence was due to the emigration of potential schizophrenic patients or to the immigration of a non-risk population. The annual first-admission rate for first admission schizophrenia decreased in Finland during the 1980s, but increased slightly thereafter (Salokangas et al., 2010); thus, the trend in Western Lapland was opposite to that for the rest of Finland.

Acknowledgements

The Project was supported by a grant from the Finnish Academy of Science. We also thank the psychiatric staff of Western Lapland area for their enthusiastic participation in all phases of this project, and Professor Roar Johnsen of the University of Trondheim, Norway, for his contribution to this article.

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CHAPTER 8

Language Is Not Innocent

TOM ANDERSEN, MD

This chapter probably represents a minority position compared to the views held by most of the authors and readers of this book. It is connected to certain basic assumptions that also might be minority ones compared to those enunciated in the wider context that this book addresses. I believe that this book will be of great interest to professional therapists, politicians and administrators, the public, and maybe even more.

Let us first turn our attention to the word "assumptions" now and its context, the hermeneutic circle.

THE HERMENEUTIC CIRCLE

The hermeneutic circle is a concept usually related to two German philosophers, Martin Heidegger and Hans Georg Gadamer (Wachthauser, 1986; Warncke, 1987). Basically this concept refers to the idea that we live our lives within the frames of the life we have already lived. Heidegger says that life, or in his words, being-in-the world, is a constant search for meanings—meanings about how we can understand ourselves and our surroundings. What we thereby come to understand will influence how we relate to the surroundings as well as to those persons who are there.

What we come to understand is related to what we see and hear. And what we see and hear are related to what we look for and listen to. We do not see what we do not look for, and we do not hear what we do not listen to. Since life is so rich and so full, there is always, in any situation, much more to see than we are able to see and much more to hear than we are able to hear. It gets even more complex as the life we as therapists are particularly interested in comprises meanings and feelings that shift all the time; they are there for a second and have passed by the next second. In order to be able to grasp a meaning of what is going on, we actually have to select what we shall look at and listen to. In this act of creating meanings, we also perform an act of limitation both as ordinary persons and as therapists and scientists. We thereby also choose what we shall *not* look at and *not* listen to. Gadamer says that this act of limitation, namely what we include and what we exclude, is governed by our prejudices (Wachthauser, 1986). We have beforehand, more or less being aware of it, an understanding of what it is worthwhile to look for and listen to. The main point here is that we are prejudiced. We cannot *not* be. Heidegger (Wachthauser, 1986) uses another word for prejudice, namely preunderstanding. These basic assumptions of what we shall pay attention to and how that attention should be given are shaped and reshaped by the way we live our lives. Since the lives of various people are so different, we probably begin with different preunderstandings.

What we come to understand is more person-bounded and less general than we might want it to be. However, when we want or need to understand something particular, we might see and hear something we never saw or heard before. This new experience might feed back on our preunderstanding and subtly change it. This circular relationship between the more general preunderstanding and the special understanding is called the hermeneutic circle. Our prejudices are formed by the way we live our lives.

REFLECTING PROCESSES

As a therapist, many uneasy feelings followed my attempts to be in charge, to know what to talk about and how to do so, and to instruct the clients how they should live their lives. Working based on such therapeutic ideals will easily put the therapist on the top in a hierarchical relationship. And within a hierarchical relationship, the meanings easily are ranked as better or worse, useful or useless, wise or unwise, and the like. At least that happened when I tried to be a therapist who was expected to know and to tell what was best. The presented interventions tended to be "better" ideas than what the families had themselves. When families dared to speak up and tried to defend their ideas, battles between them and us, the therapists, about "either you are wrong or we are," broke out.

The reflecting processes became a solution to the hierarchical unpleasantness (Andersen, 1991, 1992). Letting our ideas about the families come out in the open, as the families let their ideas come to the fore, made us more equal. The hierarchical *either/or* tendencies declined, and we shifted into the frame of *both/and*.

Needless to say, we had come to a point where clients and therapists worked and talked *together*. Both parts had significant influence; the clients' influence was based on their own personal experiences, and ours was derived from our general experiences of working with many clients. Interventions and problem solutions are no longer the focus for our work, unless the clients ask for them. The talks we have together seem to bring out the alternative the clients themselves find useful—an alternative way of *being-in-the-world*.

Outer and Inner Talks

The reflecting processes can be described as shifts between talking with others about various issues and sitting back and listening to others talking about the same issues (Andersen, 1987, 1991, 1992, 1993). The talk with others is an *outer talk*, and that which one has with oneself (when listening to others' talk) is an *inner talk*. These two kinds of talking seem to deal differently with the same issue. What happens in the outer talk will be a perspective for the inner talk and vice versa. According to Bateson's assumption (1980), multiple perspectives of the same issue, when shared, will create new ideas and meanings.

BEING-IN-THE-WORLD IS BEING-IN-LANGUAGE AND BEING-IN-CONVERSATIONS

Following the Other

Being in these open talks and being in a *both/and* perspective makes it feel more natural to *follow the client*—literally. The client is given the freedom to decide what to talk about in whatever manner as long as necessary. The client who talks undisturbed,

not interrupted, often will start and pause and start again and stop and start again in order to find better words and expressions. Talking can be seen as a search through language to find the best words to utter exactly what one wants to utter.

To Listen Is Also to See

The listener (the therapist) who follows the talker (the client), not only hearing the words but also seeing how the words are uttered, will notice that every word is part of the moving of the body. Spoken words and bodily activity come together in a unity and cannot be separated.

Words Are Touching and Moving

The listener who sees as much as he or she hears will notice that the various spoken words "touch" the speaker differently. The speaker is touched by the words as they reach his or her own ears. Some words touch the speaker in such a way that the listener can see him or her be moved. Sometimes these movements are small, sometimes, big. The listener might see a shift in the face, a change in the eyes, a moving on the chair, a cough. The words that prompt these movements are the ones that particularly attract my interest.

One example may clarify this.

A woman who had felt sad for a long while related that she could never ask for help, even when she was sick. Help had to be given by others, not asked for by her. "Because," she explained, "independence was the big word in my family. We were supposed to be independent." A shift in her face and a drop in the voice when she uttered the word "independent" indicated the meaningfulness of the word. When she was asked: "If you looked into that word 'independence,' what might you see?" she first said that she did not like the word very much. Asked what she saw that she did not like, she put her hands to her face and said, weeping: "It is so hard for me to talk about loneliness . . . yes, it means staying alone." As she told how hard it had been to stay alone in order to fulfill all expectations of being independent, she cried and the body sank in resignation. She talked for a long while without interruption and started to wonder if she would be able to fulfill those expectations. Being more and more eagerly involved in her own discussion, her voice raised, her neck and shoulders raised, and she talked more and more angrily as the idea of being-in-the-world as independent were forcefully challenged.

Asked what her mother would see in the word, she replied that she would see strength; her father also would see strength, but of another kind. Her sister and grandmother would see what she did.

Answers to these kinds of questions have taught me that there are always emotions in words, other words in words, sometimes sounds and music, sometimes whole stories, sometimes whole lives.

Others have put the same strong emphasis on conversations and language in their clinical and research work. This is particularly true of those at the Houston Galveston Institute, who have inspired me a great deal (Anderson, Goolishian, & Winderman, 1986; Anderson & Goolishian, 1988), and two of the therapists at the Ackerman Institute for Family Therapy in New York (Penn & Frankfurt, 1994).

SOME ASSUMPTIONS

We Are *in* Movements, *in* Feelings, and *in* Language

I used to think that we have movements and feelings and language inside us. Conversations such as the one just referred to have made me come to think the opposite way. We are *in* them: in the movements, in the feelings, and in the language. And we do not shape them, they shape us. Wittgenstein's work (Grayling, 1988) seems to support this assumption.

Talking Is Informing and Forming

Talking has an informing part as both the person him- or herself and others hear what he or she is thinking. Talking also has a forming aspect, as the person, by searching through language, reaches a meaning. When a person does this search, he or she forms not only a meaning but a being-in-the-world in that moment. Assuming that talking is a bodily activity, the whole body is formed or re-formed in the moment of an utterance. My utterances constitute my many selves. We do not have one self but many selves as our utterances change. This assumption already has been voiced by many others, such as Hans Georg Gadamer (Warncke, 1987), Ludwig Wittgenstein (Shotter, 1993), and Mikhail Bakhtin (Bakhtin, 1993; Shotter, 1993). Bakhtin takes this point further by saying that one's life is changing all the time; it is like small events tied together to a lifeline. Life is therefore "composed" of small events, which each happen only once. This is very different from those who assume that we are stems from "inner" or "deeper" structures, as Freud purported.

When I listen to a client, there is nothing behind or under the words to be interpreted and nothing behind the person's behavior. There is nothing more than what he or she says and does. Nothing more. In this framework then, there is no diagnosis!

Words Are Like Hands

Language and words are like searching hands. One might say that language is a sense organ. But words are more. Like a hand, they grasp on to meanings. So, the words we select influence the meanings we come to reach.

Words are not innocent. I used to think that the thought came first, then it was conveyed through words to others. Now I think differently. We search through words in order to find the thought. As the highly respected theoretician and clinician Harry Goolishian used to say: "We don't know what we think before we have said it."

If one accepts this assumption, it becomes critical to ask: Through which language is the person to search in order to form him- or herself? What happens if we, the professionals, require the therapeutic talks to be in our professional language and our professional metaphors? What happens if that professional language is a so-called deficit or incompetence language, a language that comprises words that describe failures and shortcomings? What kind of persons are thereby formed? Gergen (1990) has expressed grave concern about this possibility. I strongly second his concern.

With his colleague Harlene Anderson, Goolishian arranged a conference on these issues in San Antonio, Texas, shortly before he died in 1991. The announcement to the conference reads:

The central theme of this conference will be the exploration of the Wittgensteinian concept that the limits of the reality that can be known are determined by the language available to us to describe it. This theme will permit us to dialogue around the implications of the "deficiency language" of the mental health field and the effect these words have on our theoretical, clinical, and research work. This theme will also address the pragmatic distinction to be made between the concepts of constructivism and social constructionism.

It is our impression that over the last century of the mental health movement we have contributed thousands of words to the vocabulary of the world. Unfortunately, most of these contributed and constructed words reflect some sense of deficiency. It seems that in many ways the deficiency language has created a psychological and theoretical reality that can be metaphorically described as a black hole out of which there is very limited escape for meaningful clinical and research activity. . . .

I believe that words in the language of pathology are constraining, and I am critical of this and concerned. One concern is that the verb to be leaves out time. When we say that he or she is this or that, that expression makes us think that the person is like that and will be like that. No person, however, is static. It is our talking about the person that makes him or her appear static.

Let me give two examples.

It is not uncommon to say something like this: "He is resistant," or "He has a character of resistance."

One could easily practice language differently and say instead: "He resists." Which makes me ask: "What makes him resist?" Perhaps I said or did something he did not like and therefore resisted. And since I believe that the only person in the world I can change is myself, I rather do or say something differently that he does not have to resist (me).

It also often happens that persons are described as depressed or as having a depression. That language usage conveys a particular understanding of the person, and that understanding contributes to how we relate to her. Why not rather let her find her own words, which most probably would be: "I am sad." If she was asked what she tells herself in her inner talks, we might learn that that talk is filled with blaming words: "You are not good enough," or "You are not kind enough"—a monologue of blaming. That might make us discuss whether there could be space for an additional inner voice speaking more friendly words (Penn & Frankfurt, 1994).

Neither individuals nor families are a certain way. They change all the time. In some periods a family is enmeshed, in others, disconnected. In some contexts, isolating, in others, social. Families are changing all the time. As therapists, it is easy to make a family that appears happy feel guilty, ashamed, and angry, if we want that. (I hope few do.) It is easy to make a family that appears angry feel sad. And it is not impossible to make a family that appears sad feel happy. I try to be a therapist who does not concentrate on what the family is but one who finds out, together with them, how they might live their lives differently.

Another concern is the strong effect labeling might have on the forming of the labeled person's future. One woman who had been hospitalized at a mental hospital for a year finally came to family therapy. Besides herself and her family and the family therapist, the doctor-in-chief at the hospital and her nurse contact at the ward were present. When she was asked if she had been given any diagnoses, she said: "a manic-depressive psychosis." When she was asked if that diagnosis made any difference, she said it changed

her life. She could no longer laugh and be happy nor be sad and cry, because she could see on the faces of those around her that they thought that she might go manic or she might become depressed. She therefore had a new inner voice speaking to her all the time: "Don't be happy and don't be sad! Don't laugh and don't cry!"

SOME OTHER ASSUMPTIONS

The fields of psychotherapy and family therapy certainly contain other preunderstandings. Many assume, as I already have indicated, that what a person says and does stems from an inner "core," that is, either a biological or a psychological structure. Others assume that what a person says and does is related to his or her position in sociological structures—the family. Many assume that such structures (biological, psychological, sociological) are stable over time, in fact, so stable that they can be described in terms of diagnoses. Some even assume that such structures are measurable and therefore can be measured. Those who hold such assumptions—the majority of the therapists—will do clinical practice and research according to them. Yet labels rarely take into account the flux in the human's being-in-the-world.

Politicians, Administrators, and the Public

Those outside the field of therapy will most probably be convinced of the majority assumptions of specialists, and probably will find diagnoses a good way to describe and categorize human fellows. I must accept that.

So what will I do if an insurance company requires a diagnosis in order to pay for my work? I would let that be part of the conversations with the client(s). *Together* we have to select which diagnosis best characterizes the situation and which one the client(s) best can be-in-the-world with. If the client(s) asks me what I think about this diagnostic bit of the work, I would say: "I don't like it, but for us to be able to work together, we have to do it." I would say *we*, not *I*.

CONCLUSION

Some words have helped me greatly. They relate to me and others and also to those who hold assumptions that are incompatible to mine. The words are: "You shall do what you believe in, and you shall not do what you do not believe in."

In closing, I sincerely hope that we, as therapists and researchers, can let those we meet with be-in-the-world in their own language and own images. That is important for them and for ourselves.

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1996.

HANDBOOK OF RELATIONAL DIAGNOSIS AND DYSFUNCTIONAL FAMILY PATTERNS

edited by

Florence W. Kaslow, PhD

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John Wiley & Sons, Inc.

New York • Chichester • Brisbane • Toronto • Singapore

1996

Crossroads

*Tom Andersen,
in conversation with Per Jensen*

Practice comes first, says Tom Andersen. It is not easy to be a hierarchically oriented psychiatrist if one wants to be part of the reflecting team, he believes. Speaking less and listening more became an important crossroad in his practice. We met for a few hours one evening to speak about the important crossroads in Tom's working life. I began by asking whether there are any special experiences that have come to mark important points of departure for him. "Experiences with contexts made a strong impression on me", he says, and he relates two of many such episodes.

"For example, when I was a young regional doctor making house calls, I saw that family and neighbours filled the kitchen. They were there to show their concern and willingness to do something if it was wanted. When I came back to the kitchen after having examined the ill person, my 'reports' produced, as a rule, relief and joy, while sometimes the seriousness of the situation got even more intense. Another example is from the psychiatric hospital in Tromsø where people who were admitted often came from far away. Most became silent and quiet, and that touched me deeply, bordering on being unpleasant, to see how powerfully they longed for home. These are just two of many examples of

how important it became to be reminded of and sensitive towards different contexts."

When you look back, what would you say characterized family therapy's early years?

"We said to people, 'we think you should think this way', meaning: stop thinking like you do, and think like us. Stop doing what you're doing, and do this instead. It was about telling people how they should live their lives. This got unpleasant after a while, and that lead to us having to give it up.

Can you give some examples of things you stopped doing?

"We stopped saying what people should do and think, and then alternatives popped up almost by themselves. It might be, for example, that instead we said, 'In addition to how you are thinking, we have thought . . .' and 'In addition to doing what you've been doing you could also consider this . . .—in addition to, that is. It became a great relief. And it was a big transition—from 'either-or' to 'this *and* this'. Without really realizing it then, I would now say that 'either-or' belongs in a world one can describe as immoveable and to what one can also call 'the non-living'. So that is to say we worked with living people as though they belonged to 'the non-living'. It felt uncomfortable, and it was a relief to move over to the 'this *and*' perspective. But we were also made to leave the closed room—where it was unpleasant to be."

The confrontation with "either-or"

It was the choice of a new direction?

"A crossroads, I call it—because I am very uncertain of to what extent this was choice. It was more having to give something up, really give it up; we couldn't continue any longer in the same way, it wasn't possible. We had to give up."

Would you say the next crossroad you would mention is the confrontation with the closed room?

"Yes, that was the next one. The ultimate confrontation with 'either-or' came during the writing of a book about Aadel Bülow-Hansen's

physiotherapy. Gudrun Øvreberg and I began to film her, and it became my job to describe everything that happened on the film, all the movements, all the sounds, and all the words—everything. We began to film in 1983, and we were finished with the book in 1986. We called it *Büllo-Hansen's Physiotherapy* (Ianssen, 1997). It was hers. We connected her name with it. Didn't want some general title, but her name. She influenced us all so strongly. We noticed in particular how she saw, but also listened. When one sees and listens, then, of course, one experiences it through the body, and then something happens in the body. Initially you feel it *with* the body, then you feel it *in* the body—and then along come the expressions and with the expressions come the meanings.

"Her influence was great and can't be fully explained. It was no doubt her refined feeling for what is appropriate and what isn't appropriate. It was during the writing of that book that we left 'either -or' for 'this *and*'. And shortly thereafter, we left the closed room, never again to return to it. Away with it!"

Can you say a little about what you mean by the expression, "the closed room"?

"Where previously we sat with the family and said, 'Now we'll take a break—so you go and be by yourselves for a while and drink coffee—and we'll think a bit more.' Then we sat there and didn't always speak very nicely about people. 'Imagine being as stubborn as he is', or, 'she is so talkative'. That was the way we talked then. It certainly wasn't particularly pleasant. But the main impetus was that I spoke with Aina Skorpen about what the reason is that we leave them. Couldn't we just sit here and talk, then they can see and experience how we discuss, how we relate to this situation? This was in 1981; it was the autumn of 1981 when this idea came. But we didn't dare do it. We thought we would continue to speak as we had done in the closed room. We thought we might end up hurting and offending people. Therefore, we didn't do it. That's the way I remember it.

"But the idea lay there and gnawed away. Then came one day when I said, 'This is the day!' So we went in to the family and asked, 'Can you join us . . .' and all that. We had been there a whole year, and this particular day—I just said, 'Here is a double set of

everything, microphones, speakers—everything'. Then we went and asked, 'Would you like to listen to what we've thought when we've thought about you?' We were probably very nervous—and I thought, what in the world, what have I done now? Then they said yes, and then we turned all the technical equipment around so that they could see and hear us."

The reflecting team

Are you saying now, Tom, that it's almost as though you can point to a particular day when the reflecting team, as it was to be called, got its name or was born?

"It was a Thursday, after dinner in March 1985; I haven't made a note of the exact date. I asked Magnus Hald and Eivind Eckhoff, 'Might you be interested in joining us in speaking out loud?' We hadn't talked about this before, but they said yes. So then I went to the door of their room and knocked and asked would you be interested in listening a bit to what we've been thinking and hoped deep down that they would say no, but then they said yes.

"The idea came in 1981, the same year that we were at the first Milan gathering, the first time they got different groups together. It was in Montisola, a little village on an island out in Lago d'Iseo—the Iseo sea. It was the first time they had one of their famous gatherings."

But the first time you actually did it was in 1985. The idea was there, but you did it first three-and-a-half years later. When you look back now at this idea and the practice that has developed from it—it has certainly become a practice that has had an enormous influence on the field and something I believe you'll find no matter where in the field you go. Can you understand this influence? The breakthrough or gravity of the idea?

"Yes, I basically can. But different therapists practice it very differently, of course. But if one does it in certain ways—for example, such as I tried to do it—it brings in a similarity of meaning which I believe appeals to many. They do what they do, we do what we do—and it is different, but it is of equal worth in many ways, just as meaningful, even though it has different meaning. And it is

striking how therapists in countries with totalitarian regimes—for example, South Americans—are very attracted to it.”

I have often heard people say about you that you were reported to have said, “I will never say anything about a person that the person will not hear”. Is that a Tom Andersen quotation?

“It might be that I said that, possibly not as strongly—*have* said, I think I should say. Because there is much one should keep to oneself—just as in ordinary life. It is purely and simply the case that some things are inappropriate to talk about. Sometimes people can’t bear to speak about something—so one doesn’t do it. There were many crossroads at that time—for example, the moment I stood in the door and said, ‘Would you like to listen to us?’ Then the therapist got up in the usual way; he thought he should go along with us, just as we’d always done before. But I said, ‘You belong here’. It was almost like having the feeling that we had abandoned him—he was left alone and abandoned. It was very unpleasant as well, but it had to be that way.”

Meeting Harry Goolishian

“When Harry Goolishian came to Northern Norway for the first time in June 1985, we talked about the problem-created system—that is, that the system is shaped in the conversation around a theme. So the therapist belonged to another system—he belonged to those who talked about the difficulties. While we talked about their way of talking about difficulties. That was a different system. But when it happened, along came the words, ‘No, you belong here’, completely by themselves. It was only long after that I understood it. But the spontaneous came from what is felt in the body.”

Someone has said that this has destroyed the possibility of an ordinary treatment conference in psychiatry.

“Well . . . destroy an ordinary treatment conference? It is, in any case, different. Yes, it is not easy to be a hierarchically oriented psychiatrist if one wishes to be a part of this. And maybe there are those who don’t wish to give up their position.”

Is there also an ethical principle you refer to with this?

"Yes, what I think is that what is unpleasant is to orient oneself away from participation in relationships the whole time. To feel the discomfort and of course think that this is an uncomfortable situation for the others as well. So I believe I would say that it is to dare to take seriously that which one feels—what one feels with the body and in the body. And we were nearing a new crossroads—'should I do this or should I . . .'. At this time we were very rational and sensible, with almost military interventions. We placed rationality before the immediate emotional reaction.

"But when one feels that this is unpleasant, and can't manage to deal with it, then one has to adjust oneself to accommodate it—then one can deal with it afterwards. Don't wait to deal with things rationally first."

The feeling comes first

You say it was a crossroads?

"Yes, to dare to let the feelings come first. All this came at once, and with it the understanding that systems are built up around conversations—that there are different conversations around the same phenomenon. We stopped talking behind a one-way mirror, for example—as we had been doing in the Milan method. While now it got quiet—because, of course, we were supposed to say something afterwards—and then it got instead that we sat by ourselves and thought about one, two, or three things. And then when we talked—then there were many things.

"That was also an important transition. Afterwards we talked less and listened more. We stopped trying to be so active and emphasized ourselves less. Emphasized ourselves less and listened more, and in that way the others were better able to assert themselves more."

When you talk about daring to put the feeling first, are there some of these places or networks that you are a part of to which you would connect this idea?

"There are two episodes I remember. The first was a meeting with a family in which a young woman was with her mother, father, and

brother, and she flew back and forth between the rooms. She was very restless. And then she began to speak badly to her mother and called her a whore and other ugly words. We stopped this, because we knew it was pointless. But by then it had gone so far that she had been able to say very hurtful things that this mother never got over. Later on I talked with the mother's grandson, and he told me that she had never gotten over it. I wondered whether I could meet with her and ask forgiveness for not stopping it before, but he suggested I not do this.

"The other was an episode with a little boy who was very restless and had concentration difficulties. During the work there was something not quite right. At that time I went hiking a lot in the mountains to think. And this episode got me thinking about how, no matter what, we had to establish who among those present wants to talk and whether there is anyone there who doesn't want to talk. We had in any case to decide what we could talk about and what we weren't going to talk about. These realizations came from these episodes.

"A new form began to assert itself. It became important to discuss with people how we should cooperate before we began the cooperation. With this, we abandoned the idea about having plans beforehand, that it was planned before we met. We had to plan together, if planning was needed at all.

"So there were a good many things that got left behind in a very short space of time. It was concentrated. For several years, two or three, we expressed ourselves with the help of *our* metaphors. We stopped doing this also. It was uncomfortable for us to make our formulations, and therefore ourselves, so central, so there was a stop to that. We began to keep ourselves within the family's expressions—only their expressions. We did not apply our metaphors at all. And then along came this about preoccupation with the expression itself."

Practice comes first

What do you mean by "the expression itself"?

"When one only emphasizes words, one can miss out on the fact that people express themselves with the help of more than words.

Where words are concerned, we can *see* that when they themselves hear their own expressions, that they can react strongly to them. For example, a speaker can react by crying, and then the point is to get hold of what they said that led to the reaction. And we don't need to be so concerned with the reaction, but, instead, with what the reaction came along with in what they said. Then we can take hold of what they said and speak a little about that. For example, if one becomes thoughtful when they hear something, we can get hold of those words that made them become thoughtful. In that way we can begin to study expressions and discuss what the expressions contain. Not what lies behind them or under them, but what is *in* the expression itself.

"This came at the beginning of the 1990s, but it lay there actually for the first time in 1988 without my being aware of it. And again it shows that practice comes first. I have seen some old video films and asked this question without being aware of it, and it is strongly connected to getting out of unpleasant situations, to abandon an unpleasant practice."

A crossroads can also have meaning or influence. Are there other crossroads you would point out as having been important?

"Crossroads, they have certainly become apparent in encounters with people—encounters with these small networks, families, and helpers. Bülow-Hansen was unbelievably sensitive in relation to identifying contexts—when she did something with her hands, she saw the reaction and she saw how she should continue the work. She is a good example of what Wittgenstein said, 'Don't think, but look!' It is easy to create theories and guesses in situations where we look too quickly and are not explorative enough, and then we don't see what is there. Then we can quickly end up guessing about what something is."

It is rare to hear you using words such as "theory" and "method". I hear, now and then, maybe, that you say these are words you prefer not to use.

"Method is often something one has planned to have along for the consultation, something one has made in another context than that in which one is working."

To see is to participate

But if you were to single out some alternatives to terms such as theory and method?

"To look and hear, to sense. Sense is to look and hear, taste, smell, feel the strokes on the skin after an impact, an impact on the body. In therapy there is, of course, much to see and hear. This one feels *with* or on the body, and then there is what we feel *in* the body. It is convoluted, but has probably to do with the breath in each expression; the in-breath is extremely sensitive. We can feel this, for example, when we yawn and when we stop breathing, a knot in the stomach, and stop breathing from the stomach. Expression is, to begin with, a bodily thing. Later on we begin to formulate ourselves—and then the point is, the whole time to see what will happen. To notice when a person reacts to their own expression and then to which word it was or which expression was it that this person reacted to in order to go back to it. It is something to work with."

What is the difference between when you were a 25-year-old therapist and now, as a 69½-year-old therapist?

"I don't know. In my case, I am not particularly different from how I was as a 25-year-old—it was, and is, the discovery of quite simply to look and to see. To look is a way in which to participate—so a therapist is a participant, I think. To see, that is to participate. If we are to take this even further, we have, with the help of Bülow-Hansen, been able to contribute to describing people who literally *are* in motion the whole time and where the movement of the breath is central. It is from there the expressions come, on the out-breath. And, in addition, I think that one participates in the shadow of the other's movement and notices that something of what they express, which is also a part of the movement, affects them. It is that we should work with. One is actually working with the movement of another by speaking about what they said.

"Harry Goolishian was an important acquaintance. He first came to Norway three months after the first reflecting team. First we were in Karasjok, and then we went down to Sulitjelma—Lynn Hoffman and Peggy Penn were also there. When they got to hear

about the reflecting team they were quiet at first, but then they asked, "Why have you done this?" and said: this is something completely new, never done it before. I understood after a short time that it would appeal, and I understood as well that it could be misused by becoming categorizing, instructive, and oppressive. Then I said to myself that if I was to write about this, I would have to be willing to travel around in order to contribute to preventing it from being misused.

"Harry came in March with the expression, the *problem-created system*. The first time he spoke about this was that trip to Norway."

Professional network

Can you say something more about what Harry and your meeting with him and participation with him has meant?

"When he was introduced in Karasjok, I saw that he had been invited to Norway because he was such a kind man. He had an unbelievably simple and warm manner with other people. He liked the fact that people liked him; he liked to have an audience. He was so unbelievably generous in his dealings with people.

"He came in June, then we'd practised this new way, and after talking with Harry a bit—this was one year after—I began to realize that we were involved in a completely new way of thinking. We stopped making family maps and everything that concerned structure. We thought about the person in a completely different way connected to the conversation, which is again connected to a topic and a situation. We gave up the word 'structure', and Harry was the first to abandon it in 1988 when we had this 'Greek kitchen' in Sulitjelma, and, after that, all the engineering words were gone."

You and Harry also shared an understanding of the word "language".

"Yes he died before he got as far as being able to describe in detail what he thought about that, what he sensed about that—for example, what John Shotter is now doing. In Harry's practice, one could sense that he had this understanding of language. It was he

who invited Ken Gergen into the whole thing, and it was he who invited Humberto Maturana and Paul Dell into the family therapy field. It was Harry who discovered them and, later, others; among them John has taken it further. Gergen speaks about language almost as though it should be something one has in a drawer: the person has a drawer, and in there lays language. Then one takes it out and uses it. While John thinks that it lies in every single movement, it is connected to the movements of the body. And I define language as all expression. The artificial division between verbal and nonverbal—this falls away, because everything is language, all expression is language. Expression with sounds, without sounds, blows, dance, of course the spoken word; singing is expression. So thus language becomes all expression and lies in the movements of the body."

I would like to speak more with you about your participation in professional networks. And not just as a participant, but also as the builder of professional networks. You have, of course, been active over many years both as a participant and as one who invites others to participate.

"I don't know exactly, but initially it was about creating meeting places. One works better together than alone, and it was certainly to a great extent about finding like minds for this thinking which was rejected by psychiatry. To begin with, it also concerned creating meeting places."

The June Seminars

Where did you meet first?

"It began with the June Seminars, the first was in 1982. The first thing we did was to create a project which was based on seven of us from psychiatry who didn't have our own quarters in Tromsø and who would work in the offices of primary care services and especially the Health Service offices. We had regular hours there, and they could use us for whatever they wanted. If they wanted to, they could join us in working with us. The idea was to meet the task so early on that we could contribute to lowering the admis-

sions to the psychiatric hospital. And there were actually fewer admissions.

"This got to be a battle with the consultants in that they wanted to place this in their own domains. In the meantime, we got support from the Social Department, who said we were to have three positions. And the administration in Troms County couldn't say no to that. But the consultants were not happy. It was an important crossroads when the experimental period was over and it was actually successful. The admissions went down, primary care was satisfied.

"So we asked the authorities whether we should continue. They went to the consultants, who thought it was a bad idea to continue. This was a strong and important blow, a cuff to the ear that got me to understand that one cannot change living systems like individual persons or organizations from outside. They can only be changed from inside themselves. So that was an important crossroads, and that was also a forerunner to the first reflecting conversations. One cannot change people from outside."

But then you created the first June Seminar in 1982, and then you invited . . .

"The first one was in Tromsø and then we had been in Italy in 1981. It was there the idea about psychiatry in the community came about. We invited one from Canada, one from Italy, and one from Belgium. But instead of talking about psychiatry in the community, everyone in Tromsø managed to twist it around to talking about psychiatry in *that* psychiatric hospital in Tromsø: too little money, too few positions—and then I thought, no more. No more conferences in the town; we had to move out to the local community.

"Then we ended up out in Gryllefjord. I have always been good at finding practical solutions, and practical problems have never been unsolvable for me. Emotional problems are another thing, but practical . . . Then came Lynn and Peggy, and we lived in fishermen's shacks. It was incredible, just incredible."

How many have you arranged?

"With the exception of two years it has been every year—until my last, which was in 2001."

International contacts

But you have also participated in many other network gatherings.

"The network is a meeting place, in which things happen by themselves. What I did with the practical aspect was important. I maintained order around the meeting times, food, beds, and travel arrangements, and I invited good people from outside who were non-instructive and who could describe their practice and who were also humanistic. So I've certainly contributed to people being able to meet, and to meet they have to meet about something interesting—we had to find something interesting that they could meet about. And then we had to make it pleasant and enjoyable. It has been important that I have made sure that everyone has been OK. I've learned that that is very important. Give people the opportunity to meet and have a good time—but also that there is a little quality, and then one has to invite some good people. I also assume that people have it in themselves, if only they get the chance, to, in a way, see it themselves. That's what I always believe when I travel around. I'm convinced that they have it. In South America now, for example—they have it in them—that is not something I should have to point out—they have it, of course, if they can just see it themselves. Every person has it in themselves."

You have participated in South America, you have been repeatedly in many different environments. Are there any among these environments that have come to mean a lot to you?

"Yes—the prison in Kalmar in Sweden. And the work with the handicapped in Uppsala—that is to say, those who are born with a handicap or develop one after illness or accident, and maybe, in particular, those who are so-called mentally handicapped. That has been very gripping. In addition I would mention the network in the physiotherapy milieu and the network over all the gatherings we've had and South America."

Psychosis

Psychosis is a phenomenon that has preoccupied you in a special way over the past few years. When did you start these psychosis networks?

"That was in 1996. Jaakko Seikkula and his colleagues in Finland were already under way. But what they were doing wasn't found anywhere else, so I thought that if they stop or if something happens to Jaakko, it will all fall apart. Then I thought that we had to get a few more posts to stand on and now there are thirty-five posts, thirty-five projects in eight different countries. But it is still going well in Jyväskylä. We move these meetings all the time, and the meetings have been held in all the countries. So, I think, they arrange them under their own conditions, for us and their people, and at the same time it becomes a meeting place. It is purely and simply to let people get the chance to see what they have in themselves and what's there. And we have to move away from this terrible idea that one has to train up or teach people. That is an arrogant position which I cannot be a part of. And this goes back again to this, about not being able to change people from the outside. It is not possible to train people."

Working against oppression

If I were to say, Tom, after hearing you, that you have often referred to some people you have met—some, I don't know if it is correct to use the word, personal destinies? How would you say such meetings have affected you? Your own practice, own thinking?

"I don't really know, myself. I certainly get very moved by people. Go along thinking a great deal about it and get filled with a restlessness in my body that won't leave me alone. So I have to often formulate something and formulate something that can be taken into other contexts. I could cite many examples both from Norway and from other countries. I will only give one example.

"It was an episode in Asunción. We were met by the consultant at the mental hospital, a woman, with whom we talked a bit. She was very serious, and it was clear that it wasn't easy for her to show us the conditions there. It was like going a hundred years back in time. Some went without clothes, some had no speech and they screamed. It was overpopulated and—ugh—we went first to the men's ward and then to the women's ward. Pål Talberg came along, and Pål actually couldn't bear to stay there and the female consultant couldn't bear it, she waited outside. It was horrible.

There was a malformed woman who lay on the floor there, and she grasped after my hands. They shouted and screamed, and one held on fast and all of them said, help me get home, help me get home.

"A tiny little woman, she stood behind a wall of iron bars that held her captive. She shouted: 'Help me get home, there are so many who want to kill me here!' A little tiny, thin woman. 'Have you spoken to anyone about this, then?' I asked. 'Yes, I have talked with God', she said. 'And what did he say?' 'Kill them before they kill you', she said. So then I thought: What should I say? I've decided that if I have a good internal discussion, then the others can see it and then I thought that: 'we have to try to do something for you'. So I went out and met with the consultant. She was interested in changing psychiatry in her country. She wanted small units in which people could live, not these big, central hospitals. I said: 'I can understand that you want to change psychiatry in your country', and then she started to cry.

"I assumed I would never see her again, but in cooperation with the University College in Tromsø we began to discuss the possibilities of doing something in South America. So it happened that the college went in for developing an educational project in cooperation between several centres. So then I went down to Buenos Aires again and spoke with the seven who were to be supervisors. The consultant from Asunción was one of them. I asked her later in private whether she remembered my visit and the episode where I said to her that if I can do something, just tell me—and then she started crying again. Now we're under way."

The fight against oppression? Is it possible to use such big words do you think?

"I would prefer to call it working against oppression."

Afraid of hurting others

If you were to point out something you have been especially happy to have participated in, is there anything that stands out as a lighthouse or anything especially important?

"It has actually been tiring, and the only way to deal with it is just

to get to work. I have actually been afraid a lot. Afraid especially of being made a fool of and being laughed at publicly and I've certainly been that. And then, of course, I'm afraid of hurting people, but that is not what I've been most afraid of. I hear that in areas of Norwegian psychiatry I have a so-called non-name. That is not particularly pleasant to hear."

This is what you answer when I ask if there is something you have been especially happy to participate in?

"I have, of course, been lucky in that I've been one of many in a growing fellowship who have wanted the same thing. Without all these others, it would never have worked. My responsibility has been to use the position I got at the university for the best."

After a class where you taught one of the first classes at Diakonhjemmet many years ago, a stalwart and solid Norwegian priest came up to me and said: "Per, you know what? I have been on holy ground." You can almost never get a better compliment after having shared something with someone, I think. But do you say that you haven't heard this properly? I mean, in the sense that you have been able to take it in and be happy about it?

"Yes, actually there was a lot that was pleasant in the summer. My childhood friends—we are eight, and five of us began school together sixty-three years ago—we gather in our summer place out in the mouth of the fjord, that is to say by the last rocks before Denmark. There I have built some small houses, and having these houses and this place filled by these childhood friends gave an intense joy I cannot describe.

"In any case, there was a meeting in England in the summer with Lynn Hoffman and John Shotter. We seem to be more and more in agreement that language is part of the body's movements and not—as one can sense within other areas of 'social constructionism'—that language is something 'we have in a drawer inside us' and which we take out and use."

The desire for new meeting places

If you look forward now, Tom, now that you know you will retire next year from Tromsø, what will you continue with?

"I'll continue probably to work with relating and relationship and with the network study in Tromsø. That will run over two years, and it may become a Master's programme. I'll continue to participate in Nordkalotten [North Calotte], but everything lives its own life. They manage well without me, but I really want to be included. Then we have this international network, the psychosis network, which also lives its own life, but they want me along there as well. The work in South America, though, that's also living its own life now. I've been in South America for fifteen years. It's almost as though I enjoy working there best.

"Then we have the rehabilitation work in Uppsala and the prison in Kalmar. And, not least, the continuation of the conference in May 2004 on coercion and voluntariness in psychiatry—even the work of preparing the conference was rewarding. These were present, among others: National Association of Relatives and Close Others in Psychiatry, Mental Health, Norwegian Psychiatric Association, Norwegian Psychological Association and the Nurses' Association.

"We got to be such a good gang that we want to continue. The idea is to make new meeting places, for example, every third month, in which we get together around success stories—that is to say, hear what they did, how they came out of the difficult stuff and back to a normal life. Maybe one of us at a time takes along their own personal and professional network and then we others listen to what happened that made it work out well. Then many can come to listen: professionals, politicians, the press, as well as families who are in the middle of their own darkness. As many as possible should be included here.

"It means a lot to me as well to try together with, for example, John Shotter, to come out with an academic proposition. We want to provide alternatives that are in accordance with the practice and the understanding of the person as an *expressive movement*, and then we have to get on with it and actually put the legacy of René Descartes behind us."

INNOVATIONS IN THE REFLECTING PROCESS

The Inspirations of
Tom Andersen

edited by

Harlene Anderson & Per Jensen

Systemic Thinking and Practice Series

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Chapter 1 excerpted from L. Hoffman, "The Art of Witnessing", in: H. Anderson & D. Gehart (Eds.), *Collaborative Therapy: Relationships and Conversations That Make a Difference* (New York: Routledge, 2006), copyright © 2006. Reproduced by permission of Routledge/Taylor & Francis Group, LLC.

First published in 2007 by
Karnac Books
118 Finchley Road
London NW3 5HT

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British Library Cataloguing in Publication Data

A C.I.P. for this book is available from the British Library

ISBN-13: 978-1-85575-487-4

ISBN-10: 1-85575-487-8

Edited, designed, and produced by Communication Crafts

Printed in Great Britain by Biddles Ltd., King's Lynn, Norfolk

www.karnacbooks.com

The June Seminars at the North Calotte

*Magnus Hald, Eva Kjellberg, Anders Lindseth,
& Pål Talberg*

The background of the June Seminars

North of the polar circle in Norway, Finland, Sweden, and Russia lies the geographical area called the North Calotte. The area is vast, barren, and sparsely populated: people living there are often long distances from the central communities and hospitals. Tromsø is the capital of North Norway. A mental hospital, Åsgård, was established there in the early 1960s to provide psychiatric services in the Norwegian part of North Calotte. The hospital was planned to have more than four hundred beds to serve a population of two hundred thousand. Humanistic currents in psychiatry in the 1960s, together with the magnitude of the catchment area, contributed to some professionals at the hospital daring to try out new routes in forming the psychiatric treatment that could be offered. They travelled out into the districts and began to work in the local communities together with the ordinary local staff. This "outdoor work" paved the way for family therapy that reached Norway in the early 1970s to gain a good foothold in this part of the country. At first, strategic and structural therapy forms were central, but as time went on the "Milan-model"

attracted a growing interest and became the starting point for the further development of the field in North Norway. Ideas about the significance of time and context in our lives became especially important. People change according to circumstances around them, and important parts of these circumstances consist of their family life and life in the local community.

Tom Andersen started his career at the University of Tromsø in 1976, and since then he has been engaged as a professor at the medical faculty in the social psychiatry division. Tom thought very early that psychiatric care should be provided as close as possible to the patients' ordinary local surroundings and that it was the specialists' responsibility to help the primary-care providers provide the psychiatric care. In the late 1970s, along with some colleagues, he launched a project to experiment with this new approach to psychiatric care and together to study "system-oriented family therapy". The outcome was very successful: inpatient care in mental hospitals was reduced by half. Everyone was pleased except the psychiatrist colleagues in the mental hospital, who were sceptical. Most importantly, the scepticism centred around the fact that the practice of the project broke with the more usual individualistic, medical-psychiatric ways of understanding and providing psychiatric care, which eventually was influential in the termination of the project. Tom and his group learned markedly that "systemic thinking and practice" must also include themselves and their relations to the surrounding society—not only the patients' communities, but their own collegial ones as well. In addition, they learned that change grows more easily from within a system; it cannot be pushed in from the outside.

It was, however, hard for those involved in the project to give up the ideas about the great significance of time and interpersonal relationships in working with psychiatric problems, and it was considered important to also let others get the opportunity to be familiar with these new ideas. In 1982 there was a large seminar in Tromsø under the headline of Psychiatry in the Local Community. Much of the attention during the seminar was, however, directed away from local communities and instead focused around the psychiatric hospital in Tromsø. This experience contributed to the recognition that when you meet and talk in a centre, you will

easily get preoccupied by what is happening in that centre. That is why meetings concerning "local" work must also be held "out there".

This was the starting point for the June Seminars, which Tom began to arrange and opened to all clinicians in northern Scandinavia interested in systemic theory and practice. The seminars were three-day meetings held in June each year, convened in out-of-the-way small communities situated far out in the mountains or on the North Atlantic coast. The settings were so remote and the facilities so modest that only those guest "lecturers" and participants came who were genuinely interested. The long days and nights under the never-setting sun invited and became the good-fortune containers for never-ending talks and meetings. Refreshed by the seminar, we would return to our widely scattered homes, looking forward to meeting again the following year, as many since have done.

The first seminar, in 1983, was in a small fishing village, Gryllefjord, on the edge of the Arctic Ocean. Lynn Hoffman and Peggy Penn came and enchanted the participants. The next year the seminar was held in another local community, and Luigi Boscolo and Gianfranco Cecchin came. The seminar has been convened at a different remote location with "interesting people"—some new to the seminars, others returning—from the "big world" each year, and attracting more people. Harry Goolishian and Harlene Anderson were two of the guests who later returned a number of times, and many from Scandinavia also travelled to visit them in Galveston and Houston, Texas. (The Appendix contains a list of the June Seminars and the guest speakers and locations.)

After the Swedes joined in 1988, the June Seminars were arranged in northern Sweden several times. In 1994 two Russians were invited, and three years later the seminar was held in Archangelsk, northwest Russia, which was the starting point for the spread of the network there. For many years the seminars constituted the theoretical base for a two-year training programme in systemic family therapy. The programme engaged about five hundred participants and has now, since 2000, moved into the College of Tromsø as a formalized education in relational and network therapy. The June Seminars continue outside this as a meeting place for reflection and development of the ongoing clinical work.

Clinical research as a social practice has been an important area for the seminars to encourage.

The June gatherings have become "meeting places". Some participants have come every year, some now and then, some only once. Those who came and come knew and know what is best for them—to participate either in the seminar discussions during the day or, instead, in the discussions during the sunny nights. Everyone is welcome to participate and all are included: that has been an important first principle. The second principle has been to bring in good speakers. The third has been to hold the seminars at the margins. People from all disciplines and all agencies have come, creating a multiple society with mixed wishes, meanings, and beliefs

The significance of the June Seminars

The June Seminars were popular from the very beginning. Though part of the reason for this success was the participants' experience of taking part in something significant, it not easy to say precisely why or in which way the seminars were so important. One reaction among the participants could be: "This has been exciting, engaging, interesting, but I don't really know what I'm left with." This statement shows the difference between the June Seminars and other seminars and courses. Ordinarily, educational programmes for social workers, therapists, and other professional helpers aim at concrete teaching and information. Although the content of the June Seminars generally was useful and informative, they also cleared the ground for something different, something that was less common: they created room for the participants to interact with the guest "lecturers" and with each other and for their own reflections. Those who took part in the seminars often experienced very concretely how their own questions and skills tied in with the themes that were presented.

The June Seminars represent a different approach: the participants' own experiences, thoughts, assumptions, and ideas are given priority—instead of the presenters' ideas of what the participants might need. In this way, the participants enter a movement in proportion to their own understanding. They have the possibility

to consider the foundation of their own understanding. They enter into a movement that also comprises themselves as understanding individuals—with their own particular cultural and geographic belonging. It is very exciting, although it is not easy to describe a concrete source of this excitement: the excitement is just as much the movement in itself as the more specific theoretical content.

Though one might think that all seminars and training programmes for professionals should try to present new information and new theories in such a way that they relate to the participants' own experiences, this, in fact, is often not the case. Even when the participants are invited to bring their own experiences, often information and theories will be given precedence over the materials and experiences that the participants bring. It is generally understood that the most important quality of such participatory education is that those who participate take in—and are able to “take in”—the presented information. In this way it is generally not too difficult for people who have been to a seminar to tell others what they have learned. But this new “knowledge” will seldom be perceived as very exciting because it does not challenge the existing way of understanding.

Today we might say that the June Seminars were ahead of their time. They underlined the importance of the practitioners' own experience, at a time that it was fairly uncommon to do so. For decades, so-called evidence-based knowledge has been given primacy as the basis for action. Confidence in knowledge has been attributed to the kind of science that tries to establish evidence for certain assumptions in a quantitative, positivistic way. Today, however, it is ever more apparent that clinical practice cannot solely base itself on assumptions, hypotheses, explanations, and theories regardless of how good the evidence is. Practical work claims, above all, embodied knowledge that appears in action and that manifests itself as an answer to the challenge that the acting subject experiences in a certain situation. In other words, practical work requires not only that the practitioner is updated in proportion to scientific knowledge, but also that she or he can relate to, and answer to, the different challenges she or he meets in everyday work. This kind of embodied knowledge must also be valued and scrutinized, just as we in the field of science demand evidence for our assumptions. The June Seminars have challenged this bodily

anchored basis for action and, in this way, contributed to the development of this kind of knowledge.

It is not enough to spend time in "the practical field" to become a wise practitioner. Time does not prevent the development of unfortunate modes of action. If the practical knowledge is to be developed, it must be challenged and reflected upon. The practitioner must become aware of her or his own way of working and the extent to which theoretical knowledge is utilized, as well as the extent to which traditions and habits determine the way in which practical work is conducted. What kind of familiarity with the context is expressed? How necessary and crucial is this kind of familiarity? Which attitudes among those involved are significant for the course of action? If clinicians can find answers to these kinds of questions, it can contribute to their practical work: a kind of research is needed that is different from research preoccupied with verifying or falsifying assumptions. An exploration of the embodied practical knowledge is required. This kind of research presupposes a "communicative space" in which the practitioner can articulate her or his own experiences and ideas and try them out in open dialogues with other practitioners. In these discussions, theoretical perspectives are needed to help the practitioners consider the meaning and importance of their experiences and thoughts. Rooted in the nature and culture of the North Calotte, the June Seminars have represented such a "communicative space" for many of the participants.

Tom's significance for the June Seminars

The seminar leaders have been invited as Tom's friends, and, with his careful and sweet attendance, he saw to it that all present could feel free to speak in their own words, and thus he brought about a very warm, friendly, and creative atmosphere. He has done this in the same way as he taught us to perform reflective talks: being very careful with the form of the talks, in the sense that the ones who invite persons to a meeting should be responsible to make room for those who come to listen to what is said but also to be free to express themselves in their own way and themselves be listened to with respect. This carefulness and space gives those invited

the possibility to create personal understanding by adding something new to what was previously known and understood. Simple and ingenious, this could not have been accomplished by anyone without Tom's firm, never-yielding belief in this "just" way to distribute power and control. Democracy in practice, Tom's work has not been favoured by all in the professional field and has been challenged by many, and he has had to stand steady in the face of many storms to protect it. For all of us in this loosely knit network who also like these ideas, Tom has been, and continues to be, the natural leader and authority by virtue of thinking a bit faster and broader and staying in these thoughts a bit longer than most of us; daring to believe what he has seen and, not least, felt in his body; and trying the new ideas that emerged from practice "out-there". Always together with others and saying he could not have done it without all those around him, Tom very carefully organized the June Seminars in all details to ensure that every participant has a place and feels at ease. He was, and is, also always there ready to talk and listen to whoever wants to discuss what is important for them. In that way, he not only takes seriously the expressions of patients and clients, but also acknowledges the significance of the experiences of colleagues.

In this respect, the June Seminars have always been a "safe place" for expressing yourself, having room for reflection, and receiving impressions. You could also say they are an open, exploring, communicating, and reflecting-room: Rare, valuable—and all in the spirit of Tom!

Appendix: The June Seminars

- 1983 Gryllefjord, Norway. "Family Therapy". Lynn Hoffman, Peggy Penn (USA)
- 1984 Kabelvåg, Norway. "The Milan Approach." Luigi Boscolo, Gianfranco Cecchin (Italy), Peggy Penn, Lynn Hoffman (USA)
- 1985 First, Karasjok, thereafter, Sulitjelma, Norway. "Systemic Family Therapy." Harry Goolishian (USA), Donald Bloch (USA), Peggy Penn, Lynn Hoffman (USA)
- 1986 Alstadhaug, Norway. "Aadel Bülow-Hansens's Physiotherapy." Gudrun Øvreberg and her physiotherapy colleagues (Norway)

- 1987 (a): Honningsvåg, Norway. "The Psychiatric Patients and Their Adjustment to the Local Community." Alexander Blount, Raphael ben Dror (USA)
- 1987 (b): Skogsholmen, Norway. "Supervision". Harlene Anderson, Harry Goolishian (USA)
- 1988 Sulitjelma, Norway. "A Greek Kitchen in the Arctic. Family Conversations Tried to Be Described in a Constructive Perspective." Heinz von Foerster, Ernst von Glasersfeld (USA), Humberto Maturana (Chile), Lynn Hoffman, Fredrick Steier (USA), Stein Bråten (Norway), Luigi Boscolo, Gianfranco Cecchin (Italy), Harlene Anderson, Harry Goolishian (USA), Tromsø group
- 1989 Skibotn, Norway. "Practical Work with Families." Judith Davidson, Martha Ratheau, Dusty Miller, William Lax, Dario Lussardi (USA)
- 1990 Melbu, Norway. "Construction, Language and Meaning in Research and Practical Work." Kenneth Gergen (USA), Harry Goolishian, Harlene Anderson (USA), Jan Smedslund (Norway), and the Tromsø group
- 1991 Alta, Norway. The seminar about the crisis along the coastline of the north of Norway was planned a year and a half ahead, but the crisis declined and so the seminar was cancelled.
- 1992 Gryllefjord, Norway. Groups from the North present their own work.
- 1993 Svolvær, Norway. "Constructed Realities: Research, Clinical Work, Theory." Margareth Wetherell, Jonathan Potter (UK), Steinar Kvale (Denmark), Harlene Anderson, Kenneth Gergen, Mary Gergen, Sheila McNamee, Jack Lannaman, John Shotter, Peggy Penn, Donald Polkinghorne, Brent Atkinson, Ron Chenail, Tom Conran (USA), Max Elden, Hanne Haavind, Sissel Reichelt, Åge Wifstad, Anders Lindseth, Magnus Hald, Tom Andersen (Norway)
- 1994 Björkliden, Sweden. Groups from the North present their own work.
- 1995 Svanvik, Norway. "Writing as a Part of Psychotherapy." Peggy Penn, Marilyn Frankfurt (USA)
- 1996 Sulitjelma, Norway. "The Conversations and the Language Influence on Practical Work and Research." Sheila McNamee, John Shotter, Harlene Anderson, Mary Gergen, Kenneth Gergen, Peggy Penn, Marilyn Frankfurt (USA), Jukka Aaltonen (Finland), Viggo Rossvær, Åge Wifstad, Anders Lindseth (Norway)

- 1997 Arkhangelsk, Russia. Professionals from Northwest Russia, North of Finland, North of Sweden, and North of Norway meet and exchange experiences and questions.
- 1998 Gällivare, Sweden. "Qualitative and Quantitative Quality-Assurance." Groups from the North
- 1999 Bodø, Norway. "Working with Children and Adolescents." Child guidance clinic Gällivare, Tumba child guidance clinic (Stockholm), Houston Galveston Institute (USA), Bodø child guidance clinic (Norway)
- 2000 Cancelled
- 2001 Sulitjelma, Norway. "The Most Important (in My Life)." Participants in the network
- 2002 Harstad, Norway. "Expressions in Supervision and Practical Work." Janet Swensson, Eva Kjellberg, Ingegerd Wirtberg, Marianne Wikman (Sweden), Gudrun Øvreberg, Ingeborg Hansen, Eli Rongved, Ingar Kvebæk, Anders Lindseth (Norway)
- 2004 Tromsø, Norway. "Appreciative, Narrative, and Reflective Language in Consultations." Elspeth McAdam (UK), Michael White (Australia), Tom Andersen, Lynn Hoffman, John Shotter, Harlene Anderson, Hilde Ingebrigtsen (USA)
- 2005 Björkliden, Sweden. Groups from the North present their own work.

INNOVATIONS IN THE REFLECTING PROCESS

The Inspirations of
Tom Andersen

edited by

Harlene Anderson & Per Jensen

Systemic Thinking and Practice Series

Series Editors

David Campbell & Ros Draper

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Chapter 1 excerpted from L. Hoffman, "The Art of Witnessing", in: H. Anderson & D. Gehart (Eds.), *Collaborative Therapy: Relationships and Conversations That Make a Difference* (New York: Routledge, 2006), copyright © 2006. Reproduced by permission of Routledge/Taylor & Francis Group, LLC.

First published in 2007 by
Karnac Books
118 Finchley Road
London NW3 5HT

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British Library Cataloguing in Publication Data

A C.I.P. for this book is available from the British Library

ISBN-13: 978-1-85575-487-4

ISBN-10: 1-85575-487-8

Edited, designed, and produced by Communication Crafts

Printed in Great Britain by Biddles Ltd., King's Lynn, Norfolk

www.karnacbooks.com

Networks on networks: initiating international cooperation for the treatment of psychosis

Jaakko Seikkula

On a visit to Falun in Sweden in June 1995, Tom Andersen, myself, and the local team working with psychotic patients got the idea of proposing a meeting place for psychiatric units that wanted to develop new, more humane practices in treatments for psychosis. Tom had been travelling around in different countries and in different psychiatric contexts and had encountered a shared need for an alternative to mainstream psychiatry. Mainstream psychiatry meant a treatment that focused on controlling psychotic symptoms and psychotic behaviour by heavy medication from the outset and by inpatient treatment for long periods. In Falun, the acute team had received interesting experiences after decommissioning a hospital ward for psychotic patients and organizing a psychosis team instead. In addition to the inspiration of Tom Andersen's reflective processes, they had their inspiration from both psychodynamic individual psychotherapy, having as their supervisor Murray Jackson from the United Kingdom, and the need-adapted approach from Turku in Finland; they had met Professors Yrjö Alanen and Viljo Rökköläinen.

At that time I myself had already been invited to several places for presenting experiences from Finnish Western Lapland of the

new family- and social-network-oriented treatment of psychosis. Immediately I agreed with Tom's suggestion of organizing a forum for psychiatric units. This happened for the first time in 1996, and Falun was the obvious host for this very first meeting. When planning the forum, we thought that it should be organized in a different way compared to "traditional" international cooperation. Instead of building up an organization to oversee and organize the meetings, we decided to see if it would be possible arrange it such that different psychiatric units would host the meetings each in their own turn. The other idea was that the meetings should not be planned in detail in advance but, instead, should introduce the possibility for dealing with experiences on three levels:

1. to share experiences in clinical practice;
2. to share experiences on an epistemological level concerning how we understand psychotic problems;
3. to share experiences of how we describe our practice and how we develop research on what we are doing.

Concretely we organized a general frame for each of the five days of a meeting. At each meeting, we would come together on Wednesday night to plan the conference. On Thursday, we would work in small groups on different subjects concerning our clinical practice; we called this the "Clinical Day". On Saturday, the focus would be on research and descriptions of our work; over the years this day has been named "Research Day". For the first meeting in Falun, we proposed that on Friday local people could be invited to listen to our presentations to make our work more known among other professionals, patients, and relatives of the patients; this was named the "Open Day". Because of cheaper air flights, we decided to stay over the Saturday night, and thus Sunday morning was reserved for summarizing the experiences of the previous days and planning for future meetings, should there be a need for it.

The very first meeting was a success. More than twenty units accepted the invitation and came to share their experiences. Many were from Sweden, but there were also two from Finland, some from Norway, and even one unit from Germany. Because we wanted to build bridges across cultural boundaries, we decided to invite some professionals we knew from Estonia and Lithuania. Their

invitation required economic support, and this was organized by the Institute for Community Medicine in the University of Tromsø. The Swedish East European Committee subsequently contributed additional economic support to the network to make it possible for units from Latvia and Russia to participate as well.

The content of the meeting was extremely refreshing for us. People eagerly shared their experiences of clinical practice. One specific group focused on treatment where the outcome was not that expected. In annual meetings afterwards, this group became a custom and was named the "failure-case seminar". For us, this spoke of the security of the network: it was possible to share in a safe form all types of experiences, including the most difficult ones. The Open Day aroused enormous interest among local professionals, patients, and relatives. Some presentations were attended by several hundred people.

We had succeeded in opening a forum for describing our clinical practices and talking about research. This had to be approached in a careful way, because research has always been a loaded subject at our meetings. Already in the first meeting some were interested in discussing qualitative analysis of the treatment process. A proposal was made that we had to start to follow up our new way of working to make it more known and acceptable to other professionals and politicians. In the first meeting, some experiences were shared on doing research in Western Lapland on first-episode psychotic patients. Many professionals, however, felt that traditional psychiatric research is based on objectifying the patients and pathologizing psychotic behaviour, and for that reason statistical analysis should be avoided. Quite heavy arguments were used both for and against the idea of follow-up. No decision could be reached at the first meeting.

In concluding the first conference, many of us felt that a new tradition had been established. We decided to meet the following year, and the psychiatric unit in Jorvi Hospital in Espoo, Finland, took responsibility for hosting that meeting. Each year since then, a different unit has accepted the challenge of inviting other units to a meeting. Both the number of units and the numbers of participants have increased. In the tenth meeting in Roskilde, Denmark, about a hundred and seventy participants attended. We have visited Pärnu (Estonia), Vesterålen and Tromsø (Norway), Tornio (Finland),

Falun and Skellefteå (Sweden), and Kaunas (Lithuania). The form of the meetings has stayed much the same, but, of course, with local variations based on how the host unit chooses to organize the meeting. Some indication of the importance of the meetings is that during the Open Day in Tornio about four hundred people from all over Finland attended; in Skellefteå, about five hundred attended, mostly from the province around; and, in the second visit to Falun, about seven hundred attended.

The Clinical Day has maintained its popularity and significance throughout. But a most remarkable success has happened in the Research Day. Professors Anders Lindseth and John Shoter opened an important forum for a qualitative description of the treatment process. In 2001 we finally succeeded in deciding to begin the follow-up of first-episode psychotic patients. This happened after we concluded that it is not feasible to include all the units in the study, and therefore only those units who wished to do so are participating. Of the twelve units that decided to participate, five have succeeded in starting the registration of patients since 2002. Some first statistics have already been presented at two conferences, and this has aroused huge interest, particularly because it produces information about cultural differences in treatment.

What is it all about clinically?

There is no hierarchical structure to plan the annual meetings, nor are there any criteria as to who can attend. The basic idea from the very beginning has been to introduce a meeting place for psychiatric units that take total responsibility for psychiatric services in their catchment area. This is the distinguishing factor from the many academic meetings that focus on psychosis itself or some specified aspects of treatment. We focus on developing treatment systems based on daily clinical practice.

The units that have attended share an interest in developing a social-network-oriented approach with most severe psychiatric problems. The units also seem to agree with focusing on psychological understanding and psychotherapy in different forms with patients who have psychotic experiences. In addition, most units

seem interested in finding alternatives to hospitalization in a psychotic crisis by organizing acute teams for taking care of the crisis and thus, together with other professionals, preventing needless hospitalizations. The question of neuroleptic medication has been important throughout. We who initiated this forum had many critical questions about the over-medication of psychotic patients and thus wanted to find possibilities for such treatment processes in which neuroleptic medication is not used, and, if used, only where there is a specified need. In this, the units seem to follow different traditions. Many units share in their practice the tendency to decrease medication. At the same time, though, there are still some units that use neuroleptic medication with almost all psychotic patients, as they have always done. The distinguishing aspect seems to be whether the units have the possibilities and resources for developing alternative approaches for controlling treatment. For instance, some units in the Baltic countries only have the possibility of inpatient treatment for psychosis, and we all know that in a hospital the use of medication is more usual than in an outpatient setting.

Concerning the content of the specific approaches, the staff members in different units have different interests. Network-oriented approaches and a focus on reflective processes and open dialogue in the meetings is aimed at in all places. The main inspiration for the participants comes from variations on the reflective process that Tom Andersen has developed together with different units. But in addition, the network is inspired by the Finnish need-adapted tradition and especially the development that has happened in Finnish Western Lapland since the early 1980s. Starting in the Keropudas Hospital and spreading throughout the service system in the small province, a family- and social-network-centred treatment system has been constructed. This approach has been functioning for about twenty years, and thus a lot of experience exists regarding its effectiveness and specific dilemmas. In 1984, when a patient was hospitalized the hospital staff started to organize open meetings. This meant that all discussions of the actual problem and all planning of the treatment, including the origins of psychotherapeutic meaning-making, started to happen openly, in the presence of the patients. At the same time, a step was taken

away from a family therapy orientation in the sense that, in every hospitalization, the families were invited to these open meetings without any specified indication for family therapy. The new practice actually opened up a way in which the entire treatment system became reorganized and—what is perhaps even more important—understanding of psychiatric problems on a whole changed. The new practice caused new descriptions of the practice and new theories of what is important.

Another inspiration has come from Tom Andersen's work in developing reflective processes, first with his team in Tromsø and later in the many different contexts into which Tom has been invited. What is interesting is that the change from a systemic view, and organizing ourselves into family therapy teams as systemic family therapy, into an open reflection of our own observations and work happened about the same time in Tromsø as in Tornio. Tom has described (Andersen, 1991) how, during several years in the early 1980s, their team felt unease at knowing better than families how to define their problems. The change happened in January 1985 when, in one difficult situation with a family, they proposed to the therapist and to the family that the team behind the mirror could reflect openly on their ideas of what they had heard. A new way of collaboration with families was opened. As this is described in other chapters of this book, I do not go into details of the importance of reflective processes, but I think that these two cornerstones of reflective processes and open dialogue are of equal importance for the network. They both deal with openness, but they focus on slightly different aspects of openness. This is important to note, since often these ways of thinking are grouped under the same heading, and thus valuable resources that each offers individually can be missed.

In Western Lapland the approach developed into a comprehensive family- and network-centred treatment. What happened during the 1980s was that many confusing experiences of treatment emerged, because the staff did not have any useable descriptions of an open treatment system. Towards the end of 1980s, the conclusion was reached that what was needed was both a systematic analysis of the new system and systematic training of the entire staff. Several studies were conducted in 1988 on both the new

treatment processes and the effectiveness of the open dialogue approach. Starting in 1989, three years' family therapy training for the entire staff was put into practice. All this was done in cooperation between the health district and the Department of Psychology at the University of Jyväskylä. Both the studies and the full-time ongoing training offered a deeper understanding of the system. By the mid-1990s, it had become possible to give a description of the basic principles of the new approach (Seikkula, Alakare, & Aaltonen, 2001).

These principles included seven basic ideas:

1. The crisis treatment should start within twenty-four hours of contact from either the patient, a family member, or a referring authority.
2. The social network of the patient should be invited in all cases as early as possible into the open meetings, and they are invited to stay in the meetings and in the process for as long as the process is ongoing. The social network includes both the private social network of the family and all the professionals with whom the family has been in contact.
3. The staff should be flexible in adapting their treatment response to the specific and varying needs of each patient. There is no ready-made programme from case to case; rather, the best-fitting method of treatment is chosen together with the client(s). This means that different methods are integrated with each other, and thus no sensible way of working should be excluded.
4. The team contacted must take responsibility for organizing the first meetings and for taking into account everything necessary for making decisions regarding the treatment. In this, the training of the staff helps a great deal—it is not always necessary for a doctor to attend meetings to make the decisions.
5. Psychological continuity should be guaranteed by forming case-specific teams that can include staff from different units (e.g., one from social care and one from the psychiatric outpatient clinic) and across the boundary between inpatient and outpatient care. It is advisable that the same team can take

responsibility for as long as needed, not just for the crisis phase of three to five meetings.

6. The uncertainty that the crisis calls forth must be tolerated. In a crisis, no rapid conclusions or decisions are possible, so the process should create sufficient safety to tolerate this. This means that the team and the family should meet often enough—perhaps daily, in a psychotic crisis—and the quality of dialogue should be such that everyone becomes heard.
7. Dialogicity must develop, such that the meetings aim at constructing new words for experiences for which there are no words, or only symptom descriptions. The aim becomes that of focusing on dialogue itself, because in the dialogue the polyphonic resources of the networks become available.

These guiding principles for organizing a treatment system that focus on the social network's own psychological resources have proved to be a major inspiration. In many units, their own local ideas have been applied—for instance, by organizing acute teams to make possible an immediate response after the contact. In different cultures the system becomes specific to the history and the local circumstances. Among the thirty units that have participated in the meetings, there is a lot of experience regarding family and network orientation in cases of the most severe psychiatric problems. The clinical questions of the participants cover a wide variety of important dilemmas in treatment processes. Taking an example from the 2005 network meeting in Roskilde, during the Clinical Day the following subjects in small groups were handled:

- How do we understand psychosis?
- How do we generate dialogue in the best way, and what is the meaning of dialogue in the meetings?
- How do we assist organizations to become more dialogical?
- What is the best way to deal with resistance towards the new treatment coming from fellow professionals, from administration, from families?
- How do we take children's voices into account in the meetings, either as the client or as the child of a psychotic parent?
- What is the best training for open dialogues?

What is this all about concerning research?

In Western Lapland a systematic analysis of the new system became a cornerstone of the new practice. For the most part, the research was based on some ideas of social action research, in the sense that we who were involved in developing the open dialogue practice started to analyse our own work for both a greater understanding of it and for defining the problems of outcomes in the new approach. This was not, of course, fieldwork in the sense that Kurt Lewin and other founders of social action research meant. But it is still a way of making sense to ourselves of our own work with patients in severe crisis. Compared to those studies that most often are referred to in evidence-based medicine (EBM), we are always interested in having information about our practice in order to develop it further. We are not researchers outside the context and making efficacy measurements in order to have information for comparison with other studies.

As an example, the very first research project, conducted between 1988 and 2002, consisted of analysing what happens during the first contact between the patient's family and the hospital in an admission process (Keränen, 1992; Seikkula, 1991). We found out that at the boundary between the hospital and the family, a new type of interaction seems to emerge that makes it possible to use the family's own psychological resources much more than in a situation where the patient is hospitalized. An important factor is the quality of the cooperation that is generated between the family and the team. The team had to take into account a family's earlier experiences of treatment. If the family had previously experienced that hospitalization helped the patient, it was more difficult for them to accept home treatment instead of hospitalization. However, if the family did not have any experience at all from previous treatment, home treatment was easily accepted.

Another large research project, looking at open dialogues in acute psychosis, had an inclusion period of March 1992 to March 1997; there was then a five-year follow-up into the effectiveness of open dialogues. Three outcome reports have been published (Seikkula, 2002; Seikkula, Alakare, & Aaltonen, 2001; Seikkula et al., 2003, 2006) and also one on the differences of dialogues in good- and poor-outcome patients (Seikkula, 2002). Results are promising.

Compared to treatment as usual, the patients were hospitalized less; they used neuroleptic medication in about a third of the cases compared to all cases in traditional treatment; they had relapses in twenty-nine per cent compared to seventy-five per cent in the comparison group; more than eighty per cent had no remaining psychotic symptoms, compared to half of the comparison group; and eighty-one per cent had returned to employment and studies compared to thirty-eight per cent in treatment-as-usual.

The follow-up was done in a natural setting—that is, as a part of daily clinical practice. This is a quasi-experimental design, compared to experimental studies that are designated as randomized trials. In the psychosis network, the same type of follow-up in a natural setting has begun. As stated above, five centres have started to register their first-episode psychotic patients in order to follow how their treatment is taking place and what outcomes are reached after two years. This comparison is taking place in a “real-world” setting; no specific laboratory is constructed. This means that the study design does not introduce a medical pathologizing-minded model for the family and the team, as often happens in randomized trials. In the latter, qualities of the patients or the family are condensed into a few symptom ratings, and symptoms are treated using specific manualized methods.

A total of a hundred and sixty-nine patients have been included from the five centres, and their treatment is being followed. The aim of the follow-up is to obtain information about new psychotic patients in different cultures and to follow up the outcome of their treatment, using simple measurements. This information is of most value to the local units, but it also allows for the possibility of comparing the processes between different units.

New practice—new descriptions

Psychiatric treatment is organized in specific contexts by specific staff working in the units. There are few general rules that can be applied, as such. The contemporary tendency of creating rules for adequate treatment of schizophrenia and other problems seems to rely on the idea of generalized knowledge. What is problematic

is that randomized trials often create an artificial reality, and the results of trials are compared to other studies, not with other practices. In our network for the treatment of psychosis, the focus is on the actual practice in each context. This means that description of the praxis happens on its terms, not the opposite. In the annual meetings, each of us in turn has the possibility for deliberating on our own practice around the same subject.

One of the main ideas behind the meetings is that there is no hierarchical structure for taking care of the network; instead, the organization of a meetings is the responsibility of whichever unit has elected to hold the meeting. Every psychiatric unit attending the annual meeting is there from their own choosing and not because of some ready-made plan of tasks. This means that a unit may decide to come some years but not others. A number of units have participated in all meetings, but many have attended most meetings. In the meetings, the professionals share a lot of time within their home unit, which illustrates the balance of a joint meeting and the local need for developing the practice.

Another main idea consists of combining the three elements of clinical practice, epistemology, and research in the same meeting. This network was not initiated for conducting a trial in which every unit participated; instead, units have different interests. Some will participate merely in the clinical discussions. Others will also participate in the qualitative research sessions but without attending the multicentre study, in which only five of the more than thirty units participate. The defining rule is that nothing is prescribed regarding how and what each shall do. This applies to both clinical practice and research issues. For instance, there is no single definition of how each should work with reflective processes; units can have their own orientation in daily clinical work. Of course, attending the annual meetings means having an interest in open dialogues and reflective processes, but these need not be the basic organizing factors in the units.

It is interesting to compare our network to the core ideas in evidence-based medicine. In EBM systems, multicentre cooperation is important. But the thinking behind the aim of the research is to conduct research projects to obtain explanations of changing mechanisms in treatment. This most often means organizing

randomized trial to creating generalizable knowledge. The action in each unit is controlled to guarantee that each unit really is working on the same principles. This is not the case in the psychosis network. We do want to increase research, but this is the case mostly because of finding tools for analysing one's own practice in the specific context to define problems, dilemmas, and successes. What is aimed at is not meta-analysis of different research centres, but a comparison of experiences.

INNOVATIONS IN THE REFLECTING PROCESS

The Inspirations of
Tom Andersen

edited by

Harlene Anderson & Per Jensen

Systemic Thinking and Practice Series

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First published in 2007 by
Karnac Books
118 Finchley Road
London NW3 5HT

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British Library Cataloguing in Publication Data

A C.I.P. for this book is available from the British Library

ISBN-13: 978-1-85575-487-4

ISBN-10: 1-85575-487-8

Edited, designed, and produced by Communication Crafts

Printed in Great Britain by Biddles Ltd., King's Lynn, Norfolk

www.karnacbooks.com

Becoming Dialogical: Psychotherapy or a Way of Life?

Jaakko Seikkula

University of Jyväskylä, Finland

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

Keywords: dialogical, psychotherapy, psychosis, psychiatric, outcomes

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

Address for correspondence: Jaakko Seikkula, PO Box 35, 40014 University of Jyväskylä, Finland.
E-mail: jaakko.seikkula@jyu.fi

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

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

From Single Psychotherapy Methods to Integration

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

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

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

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

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

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

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

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

Open Dialogue in the Therapy Meeting

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

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

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

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

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

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

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

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

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

- We could no longer apply the idea of the therapist as initiating the change in the family system by different family therapy interventions.
- We realised family work was possible in a public sector inpatient setting, although the Milan team had said that a prerequisite for systemic therapy is to stay away from the institution (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1978).
- While systemic family therapy seemed not to be the solution, we were 'forced' to look for other options. Systemic family therapy focused on seeing the problem or symptoms as a function of the family system. But in generating open dialogue we aimed at having all the different voices being heard, without any idea whether they had a function in the family system. Thus the intervention was not to initiate change in family interaction, but to generate new words and narrate new happenings.

Meeting with Dialogism

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

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

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

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

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

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

Open Dialogue as Psychiatric System

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

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

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

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

The Present Moment in Polyphonic Embodied Dialogues

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

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

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

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

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

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

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

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

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

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

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

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

Polyphony of Voices

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

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

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

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

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

A First Polyphonic Case Example: Pekka's Father

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

T: When did father die?

M: It was 4 years ago.

T: If he ... if the father could hear what we are talking about, what would he say or what kind of advice would he give in a situation like this?

M: Well ... yes ... I am sure that Dad ... Dad would be quite sad about this. He would surely show his compassion and ...

T: What would he ... how would he show his compassion? What would he say, what words would he use?

M: Well, he ... he was a kind of a old folk man who could not show everything ...

T: Hmm

M: ... he would for sure try to encourage me ...

T: Yes.

- M: ... and I think that he would handle this quite nice. That's all I can say.
- T: But what you think is that he would encourage you and he would show his compassion ... and ... that ... or this is what I hear, that he would in a way understand this situation?
- M: Yes. I was the only one of us who could handle father, after he was ...
- T: Yes ... yes
- M: ... old ...
- T: ... that he would encourage you and show his compassion. ... What do you think your mother would say, if she still could be with us here?

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

Second Polyphonic Case Example: The Silent, Curing Moment

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

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

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

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

M: I have not been recognised.

T1: You have not been recognised?

M: Throughout my life I've been excluded from the family. At last I want to get rid of this symbiotic mess.

T1: You said that 'Throughout my life I've been excluded from the family'. Then you said that 'At last I want to get rid of this symbiotic mess'. It sounds like you are saying two things at the same time?

M: ... yes ... that's what I said ... But so far I cannot say anything more about it.

T1: ... yeah.

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

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

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

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

Final Reflections

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

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

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


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

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

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Publisher: Routledge

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Psychosis

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rpsy20>

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Jaakko Seikkula ^a , Birgitta Alakare ^b & Jukka Aaltonen ^a

^a University of Jyväskylä, Psychology, Jyväskylä, Finland

^b Keropudas Hospital, Kiviranta, Finland

Available online: 09 Aug 2011

To cite this article: Jaakko Seikkula, Birgitta Alakare & Jukka Aaltonen (2011): The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care, *Psychosis*, DOI:10.1080/17522439.2011.595819

To link to this article: <http://dx.doi.org/10.1080/17522439.2011.595819>



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The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care

Jaakko Seikkula^{a*}, Birgitta Alakare^b and Jukka Aaltonen^a

^aUniversity of Jyväskylä, Psychology, Jyväskylä, Finland; ^bKeropudas Hospital, Kiviranta, Finland

(Received 21 December 2010; final version received 7 June 2011)

An open dialogue need-adapted approach was applied in Finnish Western Lapland by organizing three-year family therapy training for the entire staff, and by following the outcomes. Three inclusion periods of first-episode psychotic patients were compared. In a two-year follow-up of two consecutive periods during the 1990s (1992–3 and 1994–7) it was found that 81% of patients did not have any residual psychotic symptoms, and that 84% had returned to full-time employment or studies. Only 33% had used neuroleptic medication. A third inclusion period, covering 2003–2005, was organized to determine whether the outcomes were consistent 10 years after the preliminary period. Fewer schizophrenia psychotic patients emerged, and their mean age was significantly lower. Duration of untreated psychosis had shortened to three weeks and the outcomes remained as good as for the first two periods. It is therefore suggested that the new practice can be related to profound changes in the incidence of severe mental health problems. This is supported by the large number of local inhabitants participating in treatment meetings for crises. Professionals had learned to make early contact in the event of crisis, and by this means prevent problems from developing into more severe cases.

Keywords: first episode psychosis; community care; need-adapted approach; open dialogues

In this study, our aim was to determine the effectiveness of the Open Dialogue approach in the treatment of first-episode psychotic patients. Two research projects had already been conducted in Western Lapland, the first as part of the Finnish National API (Acute Psychosis Integrated Treatment) study (1992 to end-1993), with a continuation as the local Open Dialogue in Acute Psychosis (ODAP) project (1994–1997) (Seikkula et al., 2003; Seikkula et al., 2006). To determine how far the outcomes in the treatment of acute psychosis remained stable, a third study was conducted, examining the period 2003–2005. This paper reports on the outcomes of all these studies, focusing particularly on the longer-term stability of the outcomes. For ease of reference the periods in question will be referred to as API^{1992–1993}, ODAP^{1994–1997}, and ODAP^{2003–2005}.

*Corresponding author. Email: jaakko.seikkula@jyu.fi

The basic aim of community psychiatry is the integration of different approaches and treatment modalities during a continuous treatment process. The treatment should be adapted to the changing needs and sub-outcomes emerging during the process, forming an entity that will guarantee the best treatment for each patient (Alanen, Lehtinen, Rääköläinen, & Aaltonen 1991; Alanen, 2009). A criticism often leveled against the one-method designs mostly used in psychotherapy outcome studies is that they tend to incorporate a view of stable therapeutic needs – needs supposedly present from the very beginning of the treatment till the very end of it. Moreover, the need to have a reliable study design favors therapeutic interventions involving a similar treatment modality from case to case. This can be difficult to implement, for example in the public health sector, where patient characteristics, and treatment processes may vary from case to case, according to the specific needs of each patient and the specific context of the services.

Outcome studies in acute psychosis mostly consist of controlled designs, with the control making it possible to analyze one specific method of treatment. Few studies exist on outcomes in community psychiatry in which treatment is adapted to individual need, even if as long ago as the 1970s several (apparently well-functioning) community-based crisis intervention programs were reported (Perlmutter, 1986; Rhine, & Mayerson, 1971; Rubinstein, 1972). In recent years, assertive community treatment (ACT) has become the most intensively studied form of community psychiatry (Drake et al., 2001; Dixon, 2000; Marshall & Lockwood, 2004; Mueser, Bond, Drake, & Resnick, 1998; Verhaegh, Bongers, Kroon, & Garretsen, 2009). The model includes multidisciplinary team work, integrated care, and working within the community; it aims at adapting to everyday needs, quick crisis intervention, an assertive attitude, an individual approach, and continuity of care. Killaspy et al. (2009) found that staff members' experiences of their work showed differences compared to treatment within the usual setting. ACT team members described more varied and flexible approaches with their patients, for example in having general conversations with their clients, not only on matters related to treatment. Staff members experienced support from each other through working as a team. ACT has improved the outcomes of treatment by reducing hospitalizations and improving employment status. It has assisted in shortening the duration of untreated psychosis (DUP), and has been found cost-effective (Marshall & Lockwood, 2003). Nevertheless, not all studies have shown such positive outcomes, most notably in cases of low fidelity to the original ACT model (Bodén, Sundström, Lindström, Wieselgren, & Lindström, 2009). Fidelity appears to be important, at least in cases of first-episode psychosis (Verhaegh et al., 2009).

In these studies there are similarities to the need-adapted approach (NAA) described in this paper. In the NAA the basic aims do indeed resemble ACT in terms of stressing family-centeredness, home visits, and team work. The main difference is that the NAA integrates specific psychotherapeutic methods as a part of an overall integrated approach.

In the small Finnish province consisting of the south-western part of Finnish Lapland, community psychiatry has been developed since the beginning of the 1980s (Aaltonen, Seikkula, & Lehtinen, 2011). The outcomes and processes in the treatment of psychosis and other severe problems have been reported in many studies (Haarakangas, 1997; Keränen, 1992; Seikkula, 1994; Seikkula

et al., 2003; Seikkula et al., 2006). In the latest studies, concerning the outcomes in first-episode psychosis, discussion has focused on the exceptional five-year outcome in psychotic symptoms and employment status (Seikkula et al., 2006). Critical comments have centered on the methodology of the studies (Fris, Larsen, & Melle, 2003), insisting that not every psychotic patient could have been included, given that the outcomes are so (unrealistically) favorable.

In the study described in the first, accompanying paper (Aaltonen et al., 2011) we focused on the changes in the incidence of first-episode psychosis that took place after initiating the new approach. The aim in this second study was to determine whether the outcomes in the treatment of first-episode psychosis have remained consistent over a 10-year period.

Community treatment in western Lapland

Based on the need-adapted approach first initiated by Yrjö Alanen and his team (Alanen, 1997, 2009; Lehtinen, Aaltonen, Koffert, Rääkölöinen, & Syvälahti, 2000), a community psychiatric system was initiated in the south-western part of Finnish Lapland in the early 1980s. Progressing through a number of phases, the system has been developed to function in a consistent manner from the mid-1990s (Aaltonen et al., in press; Seikkula et al., 2003; Seikkula et al., 2006; Seikkula & Arnkil, 2006). In the community psychiatric system there are three central elements:

1. Family and Team-centeredness

The system of treatment is guided by seven main principles, established in a research project in the mid-1990s (Aaltonen et al., 1997, 2011). Hence:

- (1) the first meeting should be organized immediately, within 24 hours of contact being made with the mental health services;
- (2) the social network of the patient, including the family and the professionals working with this specific family, should always be invited to participate, from the outset and for as long as required;
- (3) the treatment should be flexibly adapted to the specific needs of the patient and the family, using the therapy methods most suited to the case in question;
- (4) the mental health systems should guarantee that specific persons/teams will take responsibility for the treatment, organizing a case-specific team that will make decisions together with the family concerning all the treatment planning and actions to be taken;
- (5) the team should aim to guarantee psychological continuity by inviting staff members from different facilities to collaborate, for as long as required;
- (6) the team should aim at promoting a sense of security, generating a therapeutic process that can tolerate uncertainty in order to mobilize the psychological resources of the family and the social network;
- (7) the team should focus on generating dialogue in the joint therapy meetings, in order to create new words and a new joint language for experiences that previously did not have words.

2. Psychotherapy Training for all Staff Members

The training of the staff consists of a one-year introductory program and a specific three-year program in family therapy (Aaltonen et al., 2011). In addition, staff members are encouraged to undergo other forms of psychotherapy training, such as individual psychodynamic or cognitive psychotherapy. The training format is based on early notions that the basic education of the staff did not give enough support to community-based and family-centered practice, with basic education being too much focused on individual treatment of the most severe mental health problems within an in-patient setting. For this reason, since 1989 the program has included multidisciplinary on-the-job psychotherapy training for the entire staff, including doctors, psychologists, nurses, social workers, and others. The group members in this training meet for one day every second week, focusing on theories, direct supervision, and working with their own family background. The trainers are mainly fellow employees in the system, people who have qualified as trainers after undergoing a total of six years of training in cooperation with the Finnish Association for Mental Health. Thus the aim has been to guarantee a training program that will allow trainers to use of the official title of Psychotherapist, in accordance with Finnish law. At the time of writing this paper the training has been going on for more than 20 years, with about 150 people in the province (population 70,000) having gone through it. The training program is organized in collaboration with the Department of Psychology at the University of Jyväskylä, where author JA acted as Professor of Family Therapy.

3. The Research Project

The ongoing research program was initiated during the 1980s, in such a way as to guarantee that the information for developing the local treatment system would be based on the systematic exploration and analysis of the outcomes and processes in the treatment (Aaltonen et al., 2011; Alanen, 2009). The most basic principle has been to focus on naturalistic designs in the real life of Western Lapland, rather than on randomized trials. The follow-up studies have been descriptive in nature, rather than aimed at identifying generalized explanatory factors for change (Seikkula et al., 2003; Seikkula et al., 2006). Throughout the studies, a variety of qualitative analyses of treatment processes have been conducted. These studies have provided important knowledge which has allowed the psychotherapeutic quality of the work to be developed (Haarakangas, 1997; Seikkula, 2002).

Study Design and Participants

The data for the present study were gathered over three periods, the aim being to determine whether the outcomes of first-episode psychosis have remained stable over a the period from 1992 until 2005 in Western Lapland. The first two periods, named (1) the API¹⁹⁹²⁻¹⁹⁹³ period (1 March 1992 until 31 December 1993; N = 36) and (2) the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ period (1 January 1994 until 31 March 1997; N = 46) have already been reported (Seikkula et al., 2002, 2003, 2006). These periods belonged to a multicenter research project, planned as part of a Finnish national project. The specific focus was on improving community treatment and increasing information concerning the place of medication in the treatment of psychosis. The project was jointly organized by the National Research and Development Center for

Welfare and Health (STAKES), Department of Psychology (University of Jyväskylä), and the Department of Pharmacology (University of Turku). It was carried out in six psychiatric treatment centers with a total catchment area of 600,000 inhabitants. one of these centers was the western Lapland catchment area.

The third period, referred to here as ODAP²⁰⁰³⁻²⁰⁰⁵ (from 1 February 2003 until 31 December 2005; N = 18), was specifically planned to gather information on first-episode psychotic patients in the daily clinical setting, with a view to determining the stability of the results after the earlier research projects. The local ethical committee gave permission for the study, and every patient gave informed written consent regarding inclusion.

The study included all first-episode patients between 16 and 50 years of age with non-affective psychosis (using DSM-III-R and DSM IV for the third period, ODAP²⁰⁰³⁻²⁰⁰⁵). The diagnosis was made in two phases. After the first meeting, the team, in conjunction with the responsible chief psychiatrist (author BA), formulated an initial hypothesis; then, after six months, having also interviewed the patients individually, the chief psychiatrist made the final diagnosis. To test reliability, an experienced psychiatrist from outside the region re-diagnosed the patients on the basis of the patient records. The diagnostic consistency of the schizophrenia diagnosis was 78% (Kappa = .453; p = .002).

The main sources of information were: (1) premorbid variables such as psychiatric and employment status at the outset, and duration of untreated psychosis (DUP) (defined as the time between first psychotic symptoms and the start of psychosocial intervention); (2) process variables, i.e. the registered number of hospital days, number of family meetings, and registration of the use of antipsychotic medication and individual psychotherapy; (3) outcome variables, i.e. registered number of relapses (defined as making a new contact for treatment after terminating the original treatment, or as an intensification of existing treatment because of new psychotic or other severe symptoms), employment status, and ratings of the mental state of the patients on the Brief Psychiatric Rating Scale (BPRS), the Global Assessment of Function Scale (GAF), and a five-category sub-scale of the Strauss-Carpenter Rating Scale (Strauss & Carpenter, 1972; Opjordsmoen, 1991). During the API and ODAP periods, the ratings were conducted jointly by two of the authors (JS and BA) using a consensus conference method. These authors worked as researchers, and were not involved as therapists in the treatment process. During the third study period, ODAP²⁰⁰³⁻²⁰⁰⁵, all the registrations and ratings were performed by an experienced nurse and author BA. The internal consistency (Cronbach's alpha) of the BPRS was .774 at the outset and .667 at the follow-up during the API¹⁹⁹²⁻¹⁹⁹³ period, and .783 at the outset and .735 at the follow-up during the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ period. During the ODAP²⁰⁰³⁻²⁰⁰⁵ period Cronbach's alpha was .730 at the outset, and .863 at the two-year follow-up.

All the ratings mentioned above were performed at the baseline and at the two-year follow-up. During the first treatment meetings, the family was interviewed to determine the duration of psychotic and prodromal symptoms prior to first contact. Author BA verified this during an individual interview with the patient. The follow-up interviews took place in the presence of both the case-specific treatment team and the family. The statistical analysis was conducted using the Pearson Chi-square in cross-tables, and a one-way analysis of variance (ANOVA) for comparison of the means of independent groups.

Attrition

Table 1 summarizes the reasons for exclusion in the follow-up interviews.

In the third ODAP²⁰⁰³⁻²⁰⁰⁵ period, more attrition took place, mainly due to emigration from the province. To some extent this illustrates a change in society, since during the 2000s there was more emigration than in the early 1990s, when the population was more or less stable. The population decreased from 72,000 in 1995 to 68,000 in 2005. The second possible reason for emigration is connected with the mean age of the patients: The patients were younger during ODAP²⁰⁰³⁻²⁰⁰⁵ and thus at an age when they might move for the sake of their studies. When one compares the variables of sex, age, employment status, diagnosis, and duration of untreated psychosis for (1) the entire "intention-to-treat" groups and (2) the patients reached in the follow-up, one significant difference can be observed. In ODAP²⁰⁰³⁻²⁰⁰⁵ the duration of untreated psychosis was higher among the dropout patients. Overall, it appears that in all three periods the groups analyzed are strongly representative of the entire "intention-to-treat" group of psychotic patients for the timeframe in question, except for a slight tendency in the third period to select for analysis cases with a shorter duration of untreated psychosis.

Results

Comparison of the groups at outset

Differences were observed in mean age, marital status, and employment status. In all these respects the group coming for treatment in 2002–2005 differed from the two groups who came in the 1990s. Psychotic patients were significantly younger in the third group; they also had a higher likelihood of being single and of studying instead of working.

Table 1. Reasons for exclusion from the study during the two-year follow-up period.

	API (01.04.1992– 31.12.1993)	ODAP(01.01.1994– 31.12.1997)	ODAP2(01.01.2003– 31.12.2005)	Total
Treatment started	39	51	27*	117
Treatment started in a unit outside OD	1	1		
Refused to participate	1	2	3	
Not reached at two-year follow-up	2	2	6	
Deceased	2	2	0	
–suicide	2**	1**	0	
– other reason	0	1	0	
Total sample at two-year follow-up	33	43	18	95

Notes: *Altogether 31 patient contacts were registered, but four were excluded because of only one treatment contact occurred and no possibility for verifying psychotic experience was realized. None of these responded to contacts for follow-up.

**All suicides took place in 1995 when a suicidal epidemic emerged in the province.

Table 2. Characteristics and premorbid adjustment at baseline of the patients reached in the follow-up within the three groups.

	API ¹⁹⁹²⁻¹⁹⁹³ (N = 34)		ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷ (N = 46)		Chi-square (N = 18)	df	p
	API ¹⁹⁹²⁻¹⁹⁹³ (N = 34)	ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷ (N = 46)	ODAP ²⁰⁰³⁻²⁰⁰⁵ (N = 46)	ODAP ²⁰⁰³⁻²⁰⁰⁵ (N = 46)			
Age	19-38	17-43	16-42	16-42			
Mean	26.6	26.8	20.2	20.2	t = 3.53	50	.001
Sex							
Male	16 (47%)	16 (35%)	9 (50%)	9 (50%)			
Female	18 (53%)	30 (65%)	9 (50%)	9 (50%)	1.8	2	NS
Marital status					9.7	6	NS
Single	20 (59%)	34 (74%)	15 (83%)	15 (83%)			
Married, living together or divorced	14 (41%)	12 (26%)	3 (17%)	3 (17%)	12.2	6	.057
Employment status					260	8	.001
Studying	11 (32%)	13 (28%)	12 (67%)	12 (67%)			
Working	14 (41%)	24 (52%)	0	0			
Unemployed	3 (9%)	6 (13%)	2 (11%)	2 (11%)			
Passive	6 (18%)	3 (7%)	4 (22%)	4 (22%)			
Diagnosis/DSM-III-R					6.23	6	NS
Brief psychotic episode	5 (15%)	11 (24%)	7 (39%)	7 (39%)			
schizophrenia (NOS)	7 (21%)	10 (22%)	4 (22%)	4 (22%)			
Schizophreniform	9 (26%)	6 (13%)	3 (17%)	3 (17%)			
psychosis							
Schizophrenia	13 (38%)	19 (41%)	4 (22%)	4 (22%)			

Note: *Unemployed* means having been working during the previous two years, but at the moment unemployed and registered as job-seeking with the employment services.

Comparison of the groups at follow-up

Treatment processes

The duration of untreated psychosis (DUP) was 3.3 months during the first ODAP period compared to 4.2 months in the API period ($p = .069$), as shown in Table 4. It declined to half a month in the ODAP²⁰⁰³⁻²⁰⁰⁵ group, the longest time being three months. The ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ group had fewer hospital days than the API group ($p < .001$), but no differences were found in a comparison between the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ and ODAP²⁰⁰³⁻²⁰⁰⁵ period. The number of family therapy meetings stayed about the same in all three periods. Neuroleptic medication was used in the first two groups in only a quarter of cases, but showed an increasing trend in the third group, in which 50% had taken and 28% were continuing to take medication (Table 3). However, this aspect may have been affected by the larger number of dropouts in ODAP²⁰⁰³⁻²⁰⁰⁵, since treatment had been terminated among those patients who were not reached at the follow-up, and according to preliminary information they were not using antipsychotic medication. In the two first groups, first generation neuroleptics were used as the antipsychotic medication, while in the third group, second generation antipsychotics were used.

Treatment outcomes

More than 70% of the patients in each period did not have a single relapse during the two-year follow-up period. Concerning residual psychotic symptoms, the ODAP²⁰⁰³⁻²⁰⁰⁵ group had significantly fewer psychotic symptoms at the two-year follow-up, but their BPRS score was higher compared to the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ group (Table 4; $p < .001$). In each group more than 80% of the patients did not have any

Table 3. Frequencies in treatment process and outcome variables in the three groups at the two-year follow-up.

	API ¹⁹⁹²⁻¹⁹⁹³	ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷	ODAP ²⁰⁰³⁻²⁰⁰⁵	Chi-square	df	P
Use of neuroleptics						
Started	9 (26%)	12 (26%)	9 (50%)	4.47	4	NS
Ongoing	5 (15%)	5 (11%)	5 (28%)			
Individual psychotherapy						
Yes	12 (33%)	21 (46%)	12 (67%)			
No	22	25	6			
No of relapses						
0	25 (74%)	38 (83%)	13 (72%)	16.1	10	NS
1	6	5	0			
2	3	2	3			
>2	0	1	2			
Employment status at two-year follow-up				7.29	4	NS
Studying or working	21 (62%)	35 (78%)	13 (72%)			
Unemployed	4 (12%)	6 (13%)	2 (12%)			
Disability allowance	9 (26%)	4 (9%)	4 (16%)			

Table 4. Means of treatment process and outcome variables in the three groups at baseline and at the two-year follow-up, t-test.

	API ¹⁹⁹²⁻¹⁹⁹³ (N = 33)		ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷ (N = 42)		ODAP ²⁰⁰³⁻²⁰⁰⁵ (N = 18)		t-value	P
	mean	sd	mean	sd	means	d		
Duration of untreated psychosis (DUP), months								
Mean	4.3	7.0	3.3	3.8	.5	.9	2.3	.001**
Range			0-13		0-3			
Hospitalization days								
Mean	25.7	44.2	9.3	18.3	13.6	27.8	.96	.001*
Range	0-124		0-89		0.83			
Number of family treatment meetings								
Mean	26.1	14.1	20.7	20.6	23.3	19.2	0.99	NS
Range	2-55		0-99		0-38			
BPRS								
Baseline	47.4	12.5	48.8	12.2	52.1	9.8	2.5	NS
Two-year follow-up	30.2	12.9	23.7	4.5	28.5	8.8	22.6	.001**
Residual psychotic symptoms								
Baseline	3.21	.64	2.98	.80	1.56	.64	.35	NS
Two-year follow-up	.50	.90	.30	.70	.17	.38	10.1	.003*

Notes: *pair comparison between API and ODAP²⁰⁰³⁻²⁰⁰⁵.

**pair comparison between ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ and ODAP²⁰⁰³⁻²⁰⁰⁵.

remaining psychotic symptoms. It was discovered that 27% of the API patients, 14% of the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ patients, and 16% of the ODAP²⁰⁰³⁻²⁰⁰⁵ patients, were living on disability allowance (Table 3). Thus in the last two periods more than 84% were studying, employed, or actively seeking employment. This result has stayed the same over a 10-year period involving different individual patients.

Discussion

The analysis was based on two different studies. The first study, covering the first two periods, has already been reported. The third period is a new one, selected for the purposes of this specific report with the aim of determining whether the outcomes obtained in the 1990s still held as the timeframe moved into the 2000s. For the most part it could be verified that this was the case, but some interesting changes were noted. First of all, the group of psychotic patients in the 2000s seemed to be different, in the sense that the patients were younger and included fewer schizophrenia patients (Table 2). The duration of untreated psychosis had declined to half a month, compared to 3.5 months during the 1990s. Second, differences occurred in the remaining psychotic symptoms, with fewer symptoms in the 2000s than in the 1990s. In other ways the outcomes – including the employment status – remained the same, so that more than 84% of the patients were capable of returning to active social life, or were in full employment, or studies. However, in the third period the relative proportion of brief psychotic episodes was higher than in the first two groups. Even taking account of this bias, the social outcome for non-affective psychoses seems to remain positive.

These results raise some interesting questions. What is the significance of the change in the configuration of the groups of first-episode psychotic patients? Western Lapland is a small province, and community mental health practice has been conducted within it since the late 1980s, i.e. covering a period of about 20 years to the end of the last inclusion period. Under the new system, the families are immediately invited to joint meetings in all cases of crisis. This has led to a positive change in the whole culture of using mental health services. This is reflected in a general trend towards earlier initiation of treatment. At the same time, the comprehensive training in both family therapy and individual therapy for all staff members has made the treatment system itself more willing to consider psychotic phenomena from a psychological and systemic viewpoint: the entire treatment system is more oriented towards the changing needs of patients, families, and their relational systems (Whitaker, 2010). All this has led a shortened duration of untreated psychosis, and to first contact tending to be made at a younger age. The overall result is that psychotic symptoms are less entrenched than is the case where psychotic patients may have been psychotic for a year before first contact (Aaltonen et al., 2011).

The second major aspect involves the importance of the social network functioning collaboratively. In each new contact those professionals who are seen as relevant are invited to joint meetings. As one element in this, the employment authorities are invited to joint therapy meetings, in order to plan rehabilitation support for clients if this should be necessary. The young patient is regarded as competent to remain in active social life, even if he/she experiences crises and possible symptoms. To a large extent this excludes the process of being “chronified” in illness – a process which is more likely when patients move to living on a disability

allowance. In psychotic crises there are particular dangers in the patient staying outside the social context, since he/she can easily interpret other people as being dangerous, and may thus try to avoid contact. In the open dialogue treatment system of western Lapland, young patients are encouraged to stay within the social context, and this seems to encourage a return to active employment and studies.

Over the 20-year period in question, the number of psychotic patients and the incidence of schizophrenia cases seem to have declined – which is an interesting phenomena in itself (Aaltonen et al., 2011). Some previous studies have indicated that the incidence of psychosis tends to show a particular increase in areas of immigration. It has been suggested that this is connected with increased drug abuse (e.g. Boydell et al., 2003). Nevertheless, other studies have shown a general decline in the incidence of psychosis and schizophrenia, especially in stable population situations. In western Lapland, the population statistics show no emigration, and in general terms the population has remained fairly stable. In Finland as a whole, the incidence of schizophrenia has once again recently started to show an increase (Salokangas et al., 2011). A small decline in the incidence of schizophrenia is not in itself surprising, but major questions arise concerning the proportion of patients who go on to develop schizophrenia among the first-episode psychosis group. This may be related to the long-term and comprehensive development of the public health treatment culture. The implication seems to be that in Western Lapland, population stability has only had minor relevance for a positive outcome, in comparison with the notable stability of the treatment culture. Continuous efforts have been made over several years to develop the culture according to the principles of the need-adapted approach, with open dialogue as an important constituent. It appears that the open dialogue, with its early engagement with mental health problems, and retention of family involvement and the social network, plays an important role in the prevention of further deterioration into schizophrenia.

In parallel with the above, some suggestions can be drawn that the long-term development of the system has changed the overall culture of the basic population in a more positive direction in relation to all psychiatric treatment. This is reflected in earlier initiation of treatment processes, often within prodromal phases, and in an increased openness in participating psychiatric treatment. In western Lapland a large proportion of the local population has participated in therapy meetings. Every year, about 1500 patients undergoing acute psychiatric crises are met, and in nearly all cases at least closest family members participate in the first meetings. It can thus be estimated that every year about 4500–7000 people participate in joint therapy meetings, amounting to as much as 5–10% of the population. In this kind of setting one needs to emphasize the staff qualities that Rosen (2006) saw as necessary. In the community setting one cannot rely on the kind of day-program routines that might schedule the course of the day within an in-patient setting. What is important are the personal qualities and ways of acting of the staff – a point which highlights the need for new forms of staff-training, as called for also by Rosen (2006). In addition, Rosen believes that mental health service users should be seen as *empowered* agents, with the focus shifting away from (merely) their disabilities. This once again calls for skills on the part of the psychiatrist, who requires expertise in transdisciplinary team work, and in orientation and relational work. He/she is not merely an expert in diagnosing and in prescribing medication – although these skills are needed as well. While visiting Western Lapland, Robert Whitaker (2010) noted some elements of the new culture.

Limitations of the study

Because of the aim that the findings should have as high a level of external validity as possible, the reliability of some elements of the research methods could not be optimally guaranteed. All the ratings were used as a part of everyday clinical practice. This being so, the ratings from GAF and BPRS should only be seen as approximate indicators of psychological status and symptoms. They merely support the information taken from more objective indicators involving the number of hospital days, the number of relapses, and the employment status. Another problem arises from Western Lapland being a relatively small province. With such low-incidence problems as psychosis, long inclusion periods are needed if one is to have sufficient observations. During such long inclusion periods, possible changes in the local culture cannot be standardized, meaning that conclusions are less firm concerning the factors that may be most important in causing changes.

On the other hand, the small size of the province can also work as an advantage. Because no other mental health services are available, we can be fairly confident that all psychotic problems fell within the system described in this paper.

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Not to forget Tom Andersen's way of being Tom Andersen: the importance of what 'just happens' to us

John Shotter

Abstract: It is easy to think that Tom Andersen's central contribution was the introduction into psychotherapy and family therapy of the "reflecting team" – later to be developed into "reflecting processes." But Tom thought of himself as "a wanderer and worrier" – he was constantly reflecting on his own practice, on his *way* of 'going on', to further develop and refine it, and then continuing further to worry about the right words in which to express what seemed to be his new *way*. Each new *way* came from him reaching a 'crossroads', from not being able to continue any longer in the same way, from *stopping* something he came to see as ethically wrong, and then finding that "alternatives popped up almost by themselves" (Anderson and Jensen, 2007, p.159). There are thus many, many more features to Tom's *way* of therapy than just the reflecting process. Central to Tom's *way* of being in the world was what *came to him* as he moved around *in* the world, as a participant *in* rather than an observer *of* it. In my talk I will try to set out the many, many small detailed changes Tom made in his *way-of-being-with-others* in his meetings with them, and the large changes these small changes led to. Thus we must do more than merely commemorate his achievements, we must work out how not to forget them, ever.

The way that can be named
is not the true way
The way that cannot be named
is the true way (Tao te Ching, Lao tzu).

"What we come to form, and thereafter understand (both the formed and the forming), emerge from us being **in** language **in** conversations **in** movements **in** relationships **in** culture **in** nature (we do **not** have language, etc., in us). The Being in these various **ins** can best be understood by letting the feeling that comes (by being in these various **ins**) create its own metaphors, and let those metaphor be part of the language one searches through in order to find a meaning" (Andersen, no date).

"I see life as the moving of myself and my surroundings and the surroundings of those surroundings towards the future. The shifts of life around me come by themselves, not by me. The only thing I can do is to take part in them" (Andersen, 1992, p.54).

“I certainly get very moved by people. Go along thinking a great deal about it and get filled with a restlessness in my body that won’t leave me alone” (Andersen, 2007, p.171)

“Yes, to dare to let the feelings come first” (Andersen, 2007, p.163).

“What seems to be important is to learn what I shall *not do again*” (Andersen, 1992, p.54).

“I once was lost, but now am found/ Was blind, but now I see” (*Amazing Grace*, a Christian hymn).

When we worked together, Tom quite often would say to me: “Let the breathing come John, let the breathing come.” So that is what I will try to do in talking with you today: I will try to let what I have to say just come, by itself.

Tom Andersen was a very special kind of person. That is apparent to us all, and to all who ever met him. At the end of a little article he sent me a while ago (about a friend building a mountain path from rocks) – about which I will say much more in a moment – I was struck very much by its ending. First, he said that it was something “offered.” In other words, it was not a ‘telling’ of an event, nor a ‘reporting’ of it, it was not something that you were *required* to listen to; it was something that *might* simply be of interest, that *might* possibly matter to you. Next, he said that it is offered by “Tom Andersen (of Tromsø): Former country (medical) doctor, later psychiatrist, now an university faculty. A wanderer and a worrier”... not a “(fighting) warrior,” but an “(ceaselessly reflecting) worrier.” Each of those phrases matter, as I will make clear in a moment. But it was the last phrase – “a wanderer and a worrier” – that especially intrigued me, and has intrigued me ever since. For, as we know, Tom often talked of his “professional walk” as confronting him with a series of “road forks” or “crossroads,” that were to do, not with making a *choice* between, say, an A or a B, but to do with “having to give something up, really give it up” (2007, p.159).

Clearly, Tom had his own ‘inner lodestone’ guiding his *wanderings* and his *worryings*, his own ‘inner compass’ that was ‘pointing’ toward a ‘something’ that he never ceased to trying to achieve. It gave him a feeling of disquiet, a feeling of ‘*not-yet-having-arrived*’, of ‘*not-being-there-yet*’, “a restlessness in my body that won’t leave me alone” (p.171), a restless that ‘called’ on him to act in some way, that in Bakhtin’s (1993) terms he felt *answerable*. It is that feeling of restlessness that Tom and I shared – and it is what that something ‘is’ that Tom was aiming in his ‘answers’ to it, that I want to try to describe here. For it is not something that Tom *thought*, it is not a special *theory* or piece of information that can – if only the right words can be found – be set out as ‘his’ crucial perspective or framework. It is something he came to embody: Along with knowing how, bodily, we are walking on two rather than four feet; how we know that we walking forwards rather than sideways; that our bodies are upright rather than horizontal; that the car you are in is turning rather then going in a straight line; that are moving uphill rather than downhill; and so on and so on; these are ‘sensings’ continually present to us that work in the background to *orient* us in our more deliberate actions, a part of our *composure*, *poise* (balance), or *assuredness* in the world (Todes, 2001) – I will return to this most crucial issue more fully in a moment.

Let me just note here, that in *The Reflecting Team in Action* book (Friedman, 1995), Tom noted that: “My way of telling about the origin and development of the reflecting

process has shifted over the years. At first I often referred to theories, as if these processes were born out of intellectuality. Now I do not think so. I think rather they were consequences of feelings. Although I was unaware of it when the reflecting process first appeared in March 1985, I now think it was a solution to my feeling of discomfort as a therapist” (p.11). In other words, it was something that Tom first found ‘just happening’ in his own body, that was the basic source of the changes he made in his practice over the years.

Indeed, central to the story I am going to tell here is a distinction, a difference, between two kinds of difficulties: What Wittgenstein (1980) called difficulties of the *intellect*, and difficulties of the *will* (p.17). We can formulate difficulties of the intellect as *problems* which, with the aid of clever theories, we can solve by the use of reasoning. Difficulties of the will, however, are quite different. For they are to do with how we *orient* ourselves bodily towards events occurring around us, how we *relate* ourselves to them, the *ways* in which we see them, hear them, experience them, value them – for it is these are the *ways* that determine, that ‘give shape to’, the lines of action we further *resolve* on carrying out. But we do all this while we are already **in** action, **in** motion!

As Tom (1997) put it in a 1997 article: “A person takes part in the world as a being. *Not* the noun Being, but the verb Being: being-in-the-world, which is: being-in-(bodily)movements, being-in-language, being-in-conversations, being-in-relationships (being-with-others), being-in-culture, being-in-time (being-in-history), being-in-nature etc. To change is to be differently *in* either: movements or language or conversations or relationships.” Let me repeat that: to change is to be *differently in motion, in language, in conversation, etc.* – but this is not something strange and esoteric, it is something we are doing every moment of the day without even noticing it.

Consider, for instance, simply, how we orient ourselves in relation to someone moving towards us on the street: We do not just to see them as, on the one hand, continually changing and moving yet while, on the other hand, remaining the *same* person (as if that in itself wasn’t complicated enough!), but also as bodily moving, say, on a collision course in relation to our bodily movements. So – if we are to move to avoid them, we must keep track of them, *continuously*, wherever and however they move. We cannot take snap-shots of them intermittently, and hope that wherever they will be next can be predicted from where they were in the past – for that would be to assume that they were unable, suddenly, like ourselves, also to change course and take avoiding action. But to orient and to re-orient ourselves *continuously* to another’s movements, requires our continuously adjusting our *selves*, bodily; we have continuously to direct and re-direct both our attention *and* our own movements in relation to theirs.

Tom’s contributions to psychiatry, then, are not to do with overcoming difficulties of the intellect, not to do with inventing clever theories or with uncovering some new facts. Tom’s contributions are in the still seriously neglected realm of the possible forms of embodied *relations* that we might adopt to events occurring in our surroundings. They are to do with understanding the practicalities involved in the step-by-step unfolding dynamics of feelingful events, events that – like a piece of ‘moving’ music – occur much more in time than in space, that occur ‘inside’ our living relations with the others and othernesses around us. This is what is entailed in Tom’s claim that: “Practice comes first” (Andersen, 2007, p.1958)... but we must note that intertwined into Tom’s practices, and giving them a distinctive *style*, is a special *way* of relating himself to, or orienting himself towards others – and it is this special ‘way’ of Tom being Tom Andersen that I want to try to bring out into the open, here, today.

I first became aware of Tom Andersen, as Tom Andersen, in Houston, Texas, in May 1991. But it wasn't until November 2003, in London, that Tom and I began to work together. It took that long time because, at least on my side, at that first meeting I was too in awe of him to think for one moment of us actually working together.

Right from my first experience of him, as soon as I heard his slow, very careful way of talking, I felt the strength of a powerful presence. In his quiet calmness I felt also the working of a tremendous, dynamic, 'in-touch-ness' with the invisible 'livingness' of things, with the 'movement' of events, the working of a sensitivity and attentiveness that, to me, then, suggested access to a wisdom I knew (even though I am only a few months younger than Tom) that I did not have. At that time, I was almost wholly an academic, someone concerned to argue with other academics about people's ways of *thinking* and *talking* – although my concern even then was not with the classical idea that it is the academic's task to supply some 'good ideas' that, one-day, might be 'put into practice', but was much more to do with the idea that if we could provide an understanding of how language works, of how our use of words can influence our acting, then, *that* might be of some use to those facing the daunting task of trying to help change people's behaviour for the better.

But even then, I knew that 'talking the talk' was not at all equivalent to being able to 'walk the walk'. So, although I might have been able to talk *clever talk* 'about' how words had worked in *those* situations 'over there', *after* they had been uttered, Tom, I felt, *lived within* a time and a space of *now*; he had a *composure* that manifested a *readiness* – after a pause, after a moment of 'inner dialogue' – to respond in a 'fitting' manner to whatever might happen. But to live like that, to live in that moment of risk and uncertainty, to live with the fear of having to act yet not knowing whether your action will be 'fitting' or not, being able to trust that if it isn't, others will help out, requires, I now think, a special kind of 'attitude', a special kind of sustained 'orientation', a determination to relate oneself to events in one's surroundings in a *special kind of way*. And it is that 'way' I want to talk of today.... for it is that 'way', and the very strange state of affairs that it is 'pointing toward', that I think we need constantly to remind ourselves of.

This, I think, is very close to a Western form of Zen, to what in Zen teachings is talked of as keeping, or as not losing, our "beginner's mind," or our "original mind" (like the mind of a child). For while "in the beginner's mind there are many possibilities; in the expert's mind there are few," says Zen Master Suzuki (1974, p.21). Hence "the goal of [Zen] practice is always to keep your beginner's mind" (p.21); or, to put it another way, its is for "your mind to pervade your whole body" (p.41).

This is a goal worth achieving for a beginner's mind, or our original mind, is a "big mind," a living body-mind that – because it isn't full of *our own* thoughts, full of activities of *our own* devising – "experiences *everything* within itself" (p.35). And if one can achieve it, then what is 'out there' (in one's surroundings), and what is 'in here' (in one's thoughtful feelings, one's feelingful thoughts, and thoughtful feelingful actions), are completely 'in touch' with each other. And this, I think, is exactly what Tom achieved in his practice.

It is when we fill our body-minds with our own deliberate thoughts *about this* or *about that*, that 'we' restrict 'its' ability to be responsive *whatever* might happen around us.

That is when *big mind* becomes *small mind* – for it is when it is *already* “related to something outside itself,” says Suzuki (1974), “that mind [becomes] a small mind” (p.35). But as he remarks with respect to this ‘big mind’/‘small mind’ distinction: “Actually they are the same thing, but the understanding is different, and your attitude towards your life will be different according to which understanding you have” (p.35) – let me repeat that last phrase, “your attitude towards your life will be different according to which understanding you have.” And, I would like to add, the reverse is also the case: *your understanding of your own life will be different according to your attitude towards your own and the lives of others.*

This, I think, is where we can begin to understand Tom Andersen’s special way of being Tom Andersen: For we can, I think, find the first steps towards his way of living, of living ‘in the moment’, ‘in motion’, as arising out of a very special *attitude*, a ‘*felt need*’ to be in a certain kind of *selflessly sensitive relationship* with his surroundings, with both the *others* and the *othernesses* in them (especially the mountains), and to be able to ‘answer to’ the ‘calls’ that came to him from within those relationships.

Tom was Norwegian, and in the first book length version of *The Reflecting Team* (Andersen, 1990), he begins his account of the origins of the reflecting team, and how he and his colleagues developed it, *not* with any theories, *nor* with any talk of special practices, but with a poetic description of Norway, and especially of North-Norway: “Our country is long and thin like the stem of a tree,” he said (p.18). And he continued with six or seven more pages giving both the geographical context, and the health and social services context, within which the reflecting team and reflecting processes emerged.

Tromsø, as everyone here knows, is one of Norway’s northern counties, and “in the north people live in small places scattered over a wide area” (p.19), and are clearly disoriented if they have to travel far from home. “If 1974 is set as a start,” Tom (Andersen, 1990) says, “it should be said that many ideas and experiences had been accumulating before that time. Most of us could not give up the premise that people up north, either healthy or sick, are strongly tied to the places they come from. We thought that services should be located as much as possible within the local communities having a format of working in congruence with the clinical challenges... We clearly saw that problems easily involved many people, both relatives and professionals” (p.22). And he continues to describe the period 1974-1978 in these terms: “We were, therefore, well aware of the ideas of wholeness and relationship when in 1974 we started meeting informally searching for new models of thinking and working” (p.22).

In 1978, Tom became Professor of Social Psychiatry at the University of Tromsø. An important event at that time was the organizing of a formal group of seven professionals

Siri Blesvil, MHN; Birgit Eliassen, MHN; Anne Hertzberg, Ph.D.; Aina Skorpen, MHN;

Vidje Hansen, M.D.; and Tom Andersen, M.D.

[Close](#)

, who aimed to work in close cooperation with those in ‘first line’ mental health care, to prevent the need for psychiatric patients to be hospitalized. “The hospitalization rate declined by 40% compared with a corresponding period before the project, and this decline

[was] strongly connected to the group's work" (Hansen, 1987). And as Tom comments further: "The 'first line' of care liked this way of organizing the relationship between them and us, the 'specialists', very much. They learned more to practice psychiatry themselves" (p.23) – let me say that again: *they learned to practice psychiatry themselves*. I emphasize this as in every situation, Tom's aim was *not* that *he* should be the one to change people's lives, *everyone* should be enabled to do it for *themselves*.

But I have also emphasized that comment as I think that, if it really *is/was* the case, then it is a very important. For it points to the fact that to understand how to help mentally disturbed people, you do not need first to be specially trained in abstruse matters; it is not a cognitive matter of being in possession of hard to master facts or information or special skills; but a matter of learning an *orientation*, an *way of relating* to or *being with* the others around you – something that it not learnt intellectually in a classroom, but something that, like many other embodied orientations towards events in one's surroundings, are learnt only in the practice, in the *doing* of them.

I have emphasized these "experiences with contexts" above, as this is how Tom himself began his conversation with Per Jensen in 2006 (Anderson and Jensen, 2007), sixteen years later, in which he discussed the "crossroads" in his professional life.

Right at the start he mentioned two episodes that made an impression made on him, events that "touched him deeply.". One was when, as a young regional doctor, he made house calls: he noticed that "family and neighbours filled the kitchen. They were there to show their concern and willingness to do something if it was wanted. When I came back to the kitchen after having examined the ill person, my 'reports' produced, as a rule, relief and joy, while sometimes the seriousness of the situation got even more intense" (p.158). Another example was from the psychiatric hospital in Tromsø, when people were admitted from far away: "Most became silent and quiet" (p.158). He noticed and was deeply touched by both these events. In other words, very early on, Tom's experience of a medical examination was *not* of it as just a technical activity, a matter of working on living, suffering people "as though they belonged to the 'non-living'" (p.159). It is a *social* event, a *meeting* in which all kinds of unpredictable and 'human' things can and do happen, *and* in which very special feelings can be aroused in those who witness such 'happening' events.

Living meetings are our focal events. They are the *times* when the events of importance to us 'people-persons', concerned to help people change their lives, happen. This is why in my title I have emphasized the importance of 'just happening' events. Indeed, Per Jensen (Anderson and Jensen, 2007) in his talk with Tom noted how often he talked of being affected by people in meetings – Per: "*How would you say such meetings have affected you? Your own practice, own thinking?*". Tom: "I don't really know, myself. I certainly get very moved by people. Go along thinking a great deal about it and get filled with a restlessness in my body that won't leave me alone. So I have to often formulate something and formulate something that can be taken into other contexts" (p.171).

One can become so 'moved' by the moving expressions of others, by their suffering, that – if one is better placed, has more resources at one's disposal, is less disoriented by anxiety, etc. – one can feel a strong need to alleviate or to reduce such suffering, to the extent that it is one's own as much as theirs. Such a feeling is called *compassion* (com~with + passion; a feeling with, or a witness-passion). Tom had it in abundance. Suzuki (1974)

comments: “The beginner’s mind is the mind of compassion. When our mind is compassionate, it is boundless” (p.22).

Tom relates such an event that happened to him in the big, central mental hospital in Asunción (Paraguay). He met with a consultant psychiatrist there. It was clear, said Tom, that it wasn’t easy to show us the conditions there. “It was like going a hundred years back in time. Some went without clothes, some had no speech and they screamed... the consultant couldn’t bear it, she waited outside” (p.171). There was a tiny, thin, malformed woman lying on the floor; she grasped Tom’s hands; she shouted: “Help me get home, there are so many who want to kill me here!” “Have you spoken to anyone about this, then,” Tom asked. “Yes, I’ve spoken to God,” she said. “And what did he say?” “Kill them before they kill you,” she said. “We have to try to do something for you,” he thought... but what? Meeting the consultant again, Tom found she was wanting to change psychiatry in Paraguay, wanting small local units in which people could live, not these big central hospitals. Tom said: “I can understand that you want to change psychiatry in your country,” and she started to cry. What to do? Tom could do nothing... a feeling of helplessness... he assumed he would never see her again... but he was full of a restlessness in his body that would not leave him alone.

But back in the university in Tromsø, he and his colleagues began to discuss doing something in cooperation with several South American countries. He went to Buenos Aires and spoke with the seven people who were to be the supervisors on the project; the consultant for Asunción was one of them.

The meeting with the tiny malformed woman who grabbed his hands was not – like the butterfly flapping its wings in Beijing in March changing the hurricane patterns in the Atlantic in August (a formulation that, I think, totally fails to take the *whole* already moving background into account in which the butterfly flaps its wings) – the simple *cause* of Tom’s *resolve* to begin the South American program, but it was an influence nonetheless. The woman’s voice and other expression were a part of, as Bakhtin (1984) puts it, the “... *plurality of independent and unmerged voices...* [that] combine but are not merged in the unity of the event” (p.6) that took place in Tom and his colleagues *resolving* on the conduct of the South American program.

So when Per Jensen put it to Tom that in these kind of efforts he was, perhaps, mounting a “fight against oppression?,” Tom did not object to Per using the ‘big word’ *oppression*, but he did object to the word *fight*: “I would prefer,” he said, “to call it working against oppression” (p.172). Tom is not a *warrior*. Fighting opens no new pathways forward – not matter how noble one’s cause. Only struggling to gain an orientation within a still pathless jungle of possibilities, doing the work of trying to take a step this way and that, while suffering the risk of failure, can do that. Thus it requires courage; but it is also unrelenting hard work.

It is easy to think that Tom Andersen’s central contribution was the introduction into psychotherapy and family therapy of the “reflecting team” – later to be developed into “reflecting processes.” But Tom, as I said above, thought of himself as “a wanderer and worrier” – he was constantly reflecting on his own practice, on his *way* of ‘going on’, to further develop and refine it, and then continuing further to worry about the right words in which to express what seemed to be his new *way*. Each new *way* came from him reaching a ‘crossroads’, a ‘road-fork’, from him not being able to continue any longer in the same way, from *stopping* something he came to see as ethically wrong.

For instance, in the interview he did with Per Jensen just before he died (that I've already drawn many times above), he commented that in the early days, even before the move out of "the closed room," he and his colleagues were already changing their practices in this way. When they tried to apply the Milan approach and say to people: 'we think you should think like this', they *felt* the unpleasantness of it. For, in effect, they were saying: You should stop thinking like you do, and start thinking like us; it was about telling other people how they should live their lives. They could not continue with it.

But when: "We stopped saying what people should think and do, and then alternatives popped up almost by themselves. It might be, for example, that instead we said 'In addition to how you are thinking, we have thought...' and 'In addition to doing what you've been doing you could also consider this...' – in addition to, that is. It came as a great relief. And it was a big transition – from 'either-or' to 'this *and* this' (Anderson and Jensen, 2007, p.159).

Indeed, here is what may seem to be a small transition in practice, but if we do here what Tom might do on sensing the utterance of an important word or phrase – namely, 'going into it' to see what more we can find in it – we can find why Tom said later it was such a *big* transition: "Without realizing it then, I would now say that 'either-or' belongs in a world one can describe as immovable and to what we call also call 'the non-living'. So that is to say we worked with living people as though they belonged to 'the non-living'. It felt uncomfortable, and it was a relief to move over to the 'this *and*' perspective [i.e, *way of relating*]" (p.159).

But this move, this transition, was it a "choice," an intellectually considered deliberate move in a new direction? No, not at all – perhaps a scandalous thing to say in our current individualistic, consumerist societies, in which choice and freedom are equated. So when Per Jensen responded to Tom's account of the move he made described above, by saying (with a questioning tone): "It was the choice of a new direction?" Again, like drawing back from the use of the word *fight* and substituting the word *work*, Tom found his own inner sense of the 'shape' of his experience didn't fit the expression. The word *choice* seemed unfitting: "A crossroads, I call it – because I am very uncertain of to what extent it was choice. It was more having to give something up, really give it up; we couldn't continue any longer in the same way, it wasn't possible. We had to give it up" (p.1959).

A 'choice' is to do with overcoming a difficulty of the intellect, to do with planning an action; it is to do with looking at an action 'from the outside'. While resolving on an actual action *from within* one's own doing of it, is quite different. Bakhtin (1993) describes it thus:

"From within, the performed act sees more than just a unitary context; it also sees a unique, concrete context, into which it refers both *its own sense* and *its own factuality* and within which it attempts to actualize answerably a unique truth... To see that, it is of course necessary to take the performed act *not* as a fact contemplated from outside or thought of theoretically, but to take it from within, in its answerability... This answerability of the actually performed act is the taking-into-account in it of all the [relevant] factors... The performed act concentrates, correlates, and resolves within a unitary and unique and, this time, *final context* both the sense and the fact, the universal and the individual, the real and the ideal, for everything enters into the composition of its answerable motivation. The performed act constitutes a going out *once and for all* from within possibility as such into *what is once-occurrent*" (pp.28-29).

In other words, Tom's very practical *way* of being in the world – of him *not* viewing the events occurring around him *from the outside*, theoretically, but of being able to gain a sense of himself as being *within* their unfolding dynamics – allows him to gain an inner sense of their tremendous complexity. Thus it is not going too far, I think, to say that Tom knew how 'to move around' within that inner complexity, thus to resolve on taking a possible next step within its unfolding 'movement', a possible way to 'go on' *in* continuously updating his relations with a client. But how did Tom ever develop this capacity?

Tom attributes the beginning of his emphasis on bodily events and bodily feelings to his meeting with physiotherapist Gudrun Øvreberg, who introduced him to her teacher Aadel Bülow-Hansen. About Bulow-Hanson's way of working, Tom writes that she had

“noticed that patients who are tense tend to flex their bodies towards a ‘creeping together’ position. As they do so they tend to restrict their breathing. In order to be helpful to them, Bülow-Hansen stimulated them to stretch out and ‘open up’ their bodies. One way to do so was by inducing pain in the patient. She had noticed that if a muscle, for example, on the back side of the calf, is held with a painful grip, the pain will stimulate the person to stretch the body. When the body stretches, deeper inhalation is stimulated... [But next] when the air is exhaled, some tension in the body disappears” (Andersen, 1992, pp.58-59).

And sometimes when this happened, when after an extra strong inhalation an extra strong relaxation was experienced, Bülow-Hansen's clients would respond emotionally – for a long forgotten body-memory of much happier time in their lives would return.

As Tom saw it, what Bülow-Hansen was doing on these occasions “was a variation on Gregory Bateson's famous sentence, ‘the elementary unit of information – is a difference that makes a difference’ (Bateson, 1972, p.286). She was making a sufficiently unusual difference in the bodily experience of her patients for them to notice a change in their own inner experience of themselves, of their own inner relations to themselves – so, from feeling, say, ‘out of sorts’ or ‘beside themselves’, they could become more ‘at home’ with themselves and their circumstances.

But it was important that the difference, the disturbance in the person's being produced by Aadel Bülow-Hansen's painful grips, was not *too* painful, or else the person would just close up to protect the integrity of their being, and the stretching out and breathing in phase of them opening up would not occur. Thus, “the signs Bülow-Hansen looks for in order to know whether her hands disturb appropriately unusual,” says Tom (Andersen, 1990), “are the breathing movements of the chest. She can also watch for an indication by the bending muscles to increase their activity. If the hands tend to bypass the limits of the appropriate usual to the too unusual the breathing becomes restrained and the bendings of the muscles can be seen – the hands close, the arms may be crossed, the face wrinkles, etc.” (p.35).

In other words, it is important to distinguish in such processes as these between *three variants* of difference: “If people are exposed to the usual they tend to stay the same,” Tom suggests, but: “If they meet something un-usual this un-usual might induce a change. [But] if

the new is very (too) unusual they close up [in order to prevent any damage to their personal integrity] “ (Andersen, 1990, p.33).

It is also important to notice that, in practice, there are clear *criteria* in people's bodily expressions for distinguishing between these three variants, criteria that can also be made use of in therapeutic conversations, as Tom (Andersen 1990) notes: “All these signs can actually be noticed if a conversation contains something too unusual. In addition one might notice that the person becomes less attentive and less thinking and the responses become more reserved” (p.35). There is, then, clear *evidence* to go on as to whether one is staying ‘in touch’ with one's client, or whether one has go too far, or not far enough. Indeed, we have all experienced the glazed looks of disinterest, or the indignant looks of pain, in our everyday conversations, and tried to make adjustments so as to attain that lively ‘person-to-person’ contact in can which we touch, and thus change, each other in our very being, rather than just supplying each other with facts or information to store in our heads somewhere. And this evidence can be itemized, and be made readily recognizable. As Wittgenstein (1953) asks: “The feeling of confidence. How is this manifested in behaviour? (no.179) – by clear, unhesitating pronouncements, by immediate, undeviating movements toward a goal, etc. So, although “an ‘inner process’ stands in need of outward criteria” (no.580), it is not too difficult, in practice, to provide such criteria. And just as carpenters, say, learn the ‘tricks of their trade’ in apprenticeships they serve alongside more skilful colleagues, so can we learn the criteria relevant to our ‘trade’.

Indeed, we cannot do without them if we are to be appropriately responsive to who the person before us *is* in their expressions: “In order to stay in a conversation with a person, one must respect the person's basic need to conserve his integrity. In order to be able to do that one has to learn to be sensitive to his signs, which often are very subtle ones that indicate that our contributions to the conversation have been to unusual. One thing that helps do so, is going slow when talking with people, i.e., going so slow that they have time to let us know their responses, and for us to notice them” (Andersen, 1990, p.35).

Here, then, we have one reason for Tom's ‘slow’ way of working. But this also links in with something else he said he learnt from Bulow-Hansen (Andersen, 1995) which provides another reason: “she looked (and I assume she also heard and may be even smelled) how the other responded to her hands *before* her hands continued to work. Applied to psychotherapy, it means I have to wait and see how the other responds to what I say or do before I say or do the next thing. The next thing I say or do must be influenced by the other's response to what I just said. I have to go slowly enough to be able to see and hear how it is for the other to be in conversation. If it is too unusual, the other feels uncomfortable and lets me know through one or many signs” (p.15).

Again, I want to repeat a special phrase in what I just quoted Tom as saying: “The next thing I say or do must be influenced by the other's response to what I just said.” I repeat it, because it means that in acting like this, Tom's actions are *not* being shaped by any theories or hypotheses of his own. Indeed, Tom himself is not wholly shaping his own actions, they are being partly shaped by what his client has just said or done. In other words, in Bakhtin's (1981, 1986) words, he is acting *dialogically*, and this has at least these two important consequences: (1) One is that his client is as much responsible as he, if not more, for whatever the outcome of their meeting may be; but also, perhaps even more importantly, (2) something uniquely creative can occurs in such dialogically-structured meetings that simply cannot occur outside them. Thus, to go further: This also means that if Tom can ‘keep the conversation

going' – if after each of their own steps Tom can help his clients notice the next set of possibilities open to them for another step – then, like a native guide sensitive to the signs of 'good' and 'bad' in a chaotic jungle can help a foreign adventurer to find a hidden treasure, so can Tom help his clients to find their own pathway forward.

But it is his *continuously* responsive, embodied contact with an other's expressions, and then his following of their 'moving' expressions, no matter in what direction they might go, that is crucial, that is crucial to Tom Andersen's *way* of being Tom Andersen. It is *this* that kept him oriented toward and related with his client's *way* of being themselves, toward *their* aim in *their* acting, no matter how disturbed or disoriented they might be. And it is *this* that made it possible for him to 'go on' with them in questioning and otherwise talking with them in ways that 'invited' them in to an extensive exploration of their own *ways* of being in the world.

As Tom (Andersen, 1996) himself remarked: "The listener (the therapist) who follows the talker (the client), not only hearing the words but also seeing how the words are uttered, will notice that every word is part of the moving of the body. Spoken words and bodily activity come together in a unity and cannot be separated... The listener who sees as much as he or she hears will notice that various spoken words 'touch' the speaker differently. The speaker is touched by the words as they reach his or her own ears. Some words touch the speaker in such a way that the listener can see him or her being moved" (p.121).

It is these special 'touching' words, or 'big' words – which can 'touch' both those who hear them as well as those who utter them – that, clearly, can provide 'openings' into another person's 'world', into the things that matter to them. For such words never stand alone, like, say, the small pieces of coloured glass or stone make up a mosaic pattern. Like the term "reflecting processes" that arouse in us all the whole realm of Tom's work and its applications out in the world of our practices, our initial reactions to such words can provide us with the beginnings of, in Wittgenstein's (1953) terms, new language-games.

Thus, as I said above, Tom knew how 'to move around' within the inner complexity of an unfolding activity, an activity that he was not and could not be in control of. And he learnt this, he said, in his study of Aadel Bülow-Hansen. But I need to add here, I think, that it was no casual study!

In 1983, he and Gudrun Øvreberg made a film of her work, and it was Tom's job to describe everything that happened on the film, "all the movements, all the sounds, and all the words – everything" (Andersen, 2007, p.160). The book was finished in 1986. "She influenced us all so strongly," says Tom. "We noticed in particular how she saw, but also listened. When one sees and listens, then, of course, one experiences it through the body, and then something happens in the body. Initially you feel it *with* the body, then you feel it *in* the body – and then along come the expressions and with the expressions come meanings" (Andersen, 2007, p.160).

But how is this possible? How can feelings give rise to expressions, to words? What must be the nature of language implicit in these remarks of Tom's? For we are much more used to thinking of words as working to give us an 'inner picture' of those events over there, so that we can think about how to act on them. In other words, we are used to thinking of

language *from the outside*, intellectually, as a self-contained ‘something’ like a separate inner object that can be brought into a correspondence with outer objects to *represent* them. We are quite unused to thinking of words and feelings as somehow related inseparably with each other.

Bakhtin’s (1981, 1984, 1986) *responsive* account of language use contrasts markedly, however, with our classical, representational accounts. Indeed, central among the many other features of our *responsive* talk, is its orientation toward the future: “The word in living conversation is directly, blatantly, oriented toward a future answer-word,” says Bakhtin (1981), “it provokes an answer, anticipates it and structures itself in the answer’s direction. Forming itself in an atmosphere of the already spoken, the word is at the same time determined by *that which has not yet been said but which is needed and in fact anticipated by the answering word*. Such is the situation of any living dialogue” (p.280, my emphasis). This, I think, is the importance of our words in practice, of our bodily voiced utterances, of our expressions – it is not just the circumstances they ‘depict’, but the anticipations of next events that they arouse in both our listeners, and in ourselves, that are important. For it is these expectations, these “feelings of tendency” as William James (1890, p.255) calls them, that we can see expressed in people’s bodies.

Thus the task of looking at the details of the passing or moving events occurring in Aadel Bülow-Hansen’s ways of working on video tape, *with the aim of describing them in words*, is, I think, a crucial road-fork in Tom’s life. For there is something very special about the task of finding the right words to appropriately ‘fit’, not simply the features of a static object, but the unfolding ‘directedness’ of a stream of intertwined and thus inter-related purposeful movements. For the appropriate words have to do more than merely ‘picturing’ intermittent snap-shots of people’s positions in relation to one another. Words of that kind lie dead on the page and do not point to anything beyond themselves, so to speak; they do not arouse attention-directing expectations, nor do they arouse any action-guiding anticipations. To arrive at words that do justice to the activities ‘expressed’ on the videotape, one has to go back and forth, over and over again, in an extended dialogically-structured movement between actions and words – between the feeling shape aroused by the seen and felt bodily movements occurring on the videotape and the felt movements aroused in one by one’s words – until one feels that one has finally arrived at an intertwined unity, a unity in which words and activities are all interrelated with each other in such a way that one can feel ‘at home’ in the landscape they constitute.

Again, it is as if as a foreign adventurer, one has at last spent too much time in the jungle oneself that one no longer needs a sensitive native guide to recognize the meaning of local signs, one now knows how to orient by them oneself. And in this project, in the three years involved in writing this book (and, of course, in other activities as well), Tom was familiarizing himself with the local signs relevant to finding his ‘way around’ within whatever interactional ‘jungle’ in whichever meeting he happened to find himself in. Finding the right words to describe Bülow-Hansen’s work in this three year exploration, would be like moving around in the jungle and nailing up signs at each ‘road-fork’ as it became familiar – I won’t go down that road again...

Meetings and new meeting places are important, and were for Tom. His meeting with Harry Goolishian in Northern Norway in 1985. Here are some his words of wisdom that touched Tom deeply:

- “You don’t know what you think before you have said it, or; We have to talk in order to find out what we think.”
- “The only person you can change in therapy is yourself.”
- “Listen to what they really say, and not to what they really mean!”
- “If you want therapy to proceed quickly, then you must “go slow”.”
- “It is easier to figure out what not to do, than to know what to do in therapy”

“Always try to understand what others are trying to tell you, just don’t understand too quickly!” When we understand too quickly, we stop being curious. When we are no longer curious, we stop asking questions. When we stop asking questions, we no longer invite those with whom we are conversing to express their own opinions, theories and ideas.

(More to come)....

“If the relationship between clients and therapist is crucial, what kind of knowledge (here called knowing) would it be useful for the therapist to develop in order to contribute to the best possible (the most useful) relationship? i) Could it be (the first kind): **rational** knowing? The knowing that comes f.i. by reading books and journals and by listening to theorists, and helps us expand our abilities to explain, understand, compare, interpret etc. (to comprehend or to grasp meanings). ii) Or could it be (the second kind): **practical** knowing, that comes f.i. from watching other practitioners, which increases our repertoire of talking and acting (to have agency). iii) Or could it be (the third kind): **relational** knowing. That knowing, which is hard to learn from others, helps us find a position in relation to the other(s) such that the relationship becomes useful for those who take part in it (Shotter, 1993). iv) Or could it be (the fourth kind): **bodily** knowing that comprises all the small responses to our being-in-the-world which our five senses and our acts of breathing provides. That knowing contributes to our grasping a felt meaning of the moment, long before that meaning can be formed in words (Johnson 1987, Andersen 1995). The bodily knowing is, in this article, assumed to be significant in order to reach relational knowing.

We need them all, all the four kinds of knowing, all the time. But over the years I have come to *assume* that relational knowing and bodily knowing are the most significant of the four” (Andersen, 1997).

Tom: “... it is not easy to be a hierarchically oriented psychiatrist if one wishes to be a part of [an ordinary treatment conference]. And maybe there are those who don’t wish to give up their position.” Per Jensen: “Is there also an ethical principle you refer this “Yes, I think what is unpleasant is to orient oneself away from participation in relationships the whole time” (Andersen, 2007, pp.162-163).

(More to come)....

Conclusions

Tom is most well known, of course, for his introduction of the “reflecting team” into psychotherapy (Andersen, 1992), but I have said nothing about the “reflecting process” or “reflecting talk” today, as I have been aiming at something which I think is more crucial and distinctive to Tom’s way of being with his clients: it is his sensitivity to what I will call the ‘livingness’ of things, to living, bodily events, both his own and those of his client’s, that I think is of crucial importance in Tom’s way of being Tom Andersen. For him, the important events of life do not simply occur in the person’s mind, but in their whole body, their whole being. “When life comes to me,” he says,

“it touches my skin, my eyes, my ears, the bulbs of my tongue, the nostrils of my nose. As I am open and sensitive to what I see, hear, feel, taste, and smell I can also notice ‘answers’ to those touches from myself, as my body, ‘from inside,’ lets me know in various ways how it thinks about what the outside touches; what should be concentrated on and what not. This state of being open and sensitive to the touches from the ‘outside life’ and at the same time being open and sensitive to the answers from the ‘inside life’ is what I prefer to call ‘intuition.’ At this point in time my intuition seems to be what I rely on the most. In re-walking my professional tracks, my intuition tells me that I shall take part first, and then sit down and think about the taking part; not sit down and think first and thereafter take part. As I am sure that my thinking is with me as I take part, I have felt comfortable following what my intuition has suggested to me” (Andersen, 1992, p.55).

In saying this, Tom is emphasizing his attention to events that are not easily observable because they do not occur so much in space as in time; they as are invisibly present, so to speak, in the unfolding temporal contours of people’s living bodily expressions. It is this concern with life and the livingness of things that I have wished to emphasize in our celebration of Tom’s work here, today.

Thus I have tried in this collection of brief remarks from a number of Tom’s past articles to outline what I see as one of the major and distinctive aspects of Tom Andersen’s way of being with his clients – namely, his focus on, and unrelenting responsiveness to, people’s spontaneously occurring bodily reactions to events. But not just his responsiveness to the reactions of his clients, but to his own as well: “Sometimes”, he says, “these movements are small, sometimes big. The listener might see a shift in the face, a change in the eyes, a moving on the chair, a cough. The words that prompt these movements are the ones that attract my interest” (Andersen, 1996, p. 121). And as I noted above, we can sometimes notice that “various spoken words ‘touch’ the speaker differently ... some words touch the speaker in such a way that the listener can see him or her being moved” (Andersen, 1996, p. 121).

There are thus many, many features to Tom’s *way* of therapy. And I still have not mentioned the reflecting team and reflecting processes. I haven’t because in the time available I have wanted to emphasize what seems to me to be most central to Tom’s *way* of being in the world, and this is what *came to him* as he moved around *in* the world, what he allowed to ‘just happen’ to him as a participant *in* it rather than an observer *of* it. Thus in his professional and philosophical ‘walking’, as he liked to call it, of the past few decades, he has made many, many small detailed changes in his *way-of-being-with-others* in his meetings with them. These changes were not in themselves ‘chosen’ but ‘just happened’ – there was a choice, but

it was the choice not to do *that* again, and that was when the alternative ‘just happened’ spontaneously by itself.

In the article I mentioned earlier, which he ended by calling himself a “wandered and a worrier,” he described a friend, Quiet Storm, trying to build a rock path in the mountains (it sounds to me very like Tom himself!). He talks of his friend as having drawn up plans and beginning to move the stones where *he* wanted them to go. But: “despite much energy the stones moved to other places than the plans wanted them to be.” But after a time... “Time softened Quiet Storm’s thoughts, and it finally told his thoughts to disappear for a while, and to let the plans disappear with them. Time said: ‘The touches between the stones and hands will, when the hands move the stones and vice versa, let them (the stones and the hands) know where the places will be. There are the touches and not thoughts that will clarify where a staircase might be formed. You will also soon see that there will be more than one possibility’. As spoken so happened; the stones, ready to let the weight in them determine the moves, and the hands, supported by the back and the legs, came to see where the landing of the stones came to form the frame of possible staircases.” (Andersen, no date).

Thus, for Tom, some of his basic assumptions are “that we are first (passively) touched by our surroundings (the surroundings touch our eyes, ears, skin, nostrils, tongue and balance). We are then moved before becoming active in the moving (in order not to be moved wherever by whoever to whatever consequence), then searching through talking towards meaning which, in its turn, will be seen and heard, and which in its turn touches the surroundings and those who are there” (Andersen, no date).

If we look back, then, overall on these changes now, and if like Tom we ‘go into’ some of his sayings and actions to see *what more* we can see ‘in’ them, then I think we must be amazed. Overall, Tom has moved us out of the old, mechanical ‘clockwork’ universe and into a whole new world of living, growing, creating, and developing relationships. Although it is *intellectually* strange to us – as children still of Descartes and Newton – it is not at all strange to us in fact, in practice, for it is of course the world of our everyday lives together. But it is intellectually strange, and thus it is not easy to intellectually legitimate our actions within it... But discussions of that task are for another day.

Here, what is important for us and which we must not forget, is that we can, I think, find the first steps towards Tom’s way of living – of his living ‘in the moment’, ‘in motion’ – as arising out of a very special ‘*felt need*’ to be in a certain kind of *selflessly sensitive relationship* with his surroundings, with both the *others* and the *othernesses* in them, and to be able to ‘answer to’ the ‘calls’ that came to him from within that relationship. And we must not forget it, for – just as Tom was till ‘working’ when he died to re-orient himself and others ever toward new tasks – so is our task the same: there is a whole still largely unexplored jungle of *different kinds of relationships* ‘out there’ whose nature, whose features and characteristics, will only become familiar to us in our ‘walks’ around within it, if we can be guided by appropriate expectations and anticipations ‘in here’ – that is, if we can find and sustain that same *way of being* in our selves that Tom found within himself. It is a task full of beginnings and beginnings and beginnings... without end. Tom had not finished when he died.

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Notes:

Language, Joint Action, and the Ethical Domain:

The importance of the relations between our living bodies and their surroundings

John Shotter

Emeritus Professor of Communication
University of New Hampshire, U.S.A.

“Monologism, at its extreme, denies the existence outside itself of another consciousness with equal rights and equal responsibilities, another *I* with equal rights (*thou*). With a monologic approach (in its extreme pure form) *another person* remains wholly and merely an *object* of consciousness, and not another consciousness. No response is expected from it that could change anything in the world of my consciousness. Monologue is finalized and deaf to other’s response, does not expect it and does not acknowledge in it any force” (Bakhtin, 1984, pp.292-293).

As soon as I begin an interchange of looks with another person, and I sense them as looking toward me in a certain way (as they see me looking toward them in a particular way too), a little ethical and political world is created between us. We each look toward each other expectantly, *with anticipations*, some shared some not, arising from what we have already lived through so far in our lives with all the others around us. Indeed, to put the point more generally, in any living contact between any two or more human beings, in the *meetings* between us, at least two things of importance occur: (1) Yet another form of life emerges between us, a collective or shared form of life with *its own unique character* and *its own unique world*, in whose terms, for the duration of our meeting, we can *mean* things to each other. But also, within this world, (2) we are ‘present’ to each other *as who are*, at least to a minimal extent, we can ‘see into’ each others ‘inner lives’ – hence, if it is a stranger with whom we have become involved, we quickly look away again, lest we reveal too much of ourselves unnecessarily.

In our living contacts with an other or otherness, then, our mere surroundings are transformed into ‘a world’, or at least, into a partially shared world that we sense ourselves as being *in* along with the others and othernesses around us. And besides having an ethics and politics to it – besides our having expectations within it as to how the others around us should treat us and are likely to treat us – our partially shared world has, we feel, a unique culture to it. For each of us, it is full of a certain set of interconnected ‘things’ (seemingly) that matter to us, that have certain values for us, and in relation to which we each take on a certain identity and adopt a certain stance: for instance, I am a psychologist or psychiatrist surrounded by people who require the kind of help I can offer them; I am an architect worrying about both the efficient and exciting use of space; I am a mathematician surrounded by other mathematicians, a painter surrounded by the world of art, a musician, a student of history, a construction worker, etc., etc.

But overall, I am simply a person with a ‘life of my own’ among other such persons also with ‘lives of their own’, with us all expecting in our meetings with each other to be treated as such.

These, then, are the overall questions I want to explore in this talk: How is it that we can gain this kind of sense of another person as having, in relation to us, an ‘*inner life of their own*’ – that what

confronts us is not just an object, but another living *consciousness*, with his or her *own way* of being in the world? And what, ethically (and politically), is entailed in our coming to an understanding of *them*, of *their* life, their *inner life* – not just in *our* terms, but in *theirs*?

Joint action and the joint, dialogical nature of our utterances

At this point, it will be useful to discuss three things: 1) the nature of that special sphere of activity that elsewhere I have called "joint action" (Shotter, 1984, 1995), and Bakhtin (1981; 1986) calls "the dialogical;" 2) the importance of Bakhtin's (1986) focus upon *utterances* as our investigative units; and 3) the fact that our utterances have their 'life' *in relation to their surroundings*, and have no life, so to speak, on their own – in other words, they occur within what Bakhtin (1986) calls "speech genres." To turn to "joint action" first:

1) *Joint action*: As living beings, as open systems, we cannot not be responsive to events happening around us. In such a sphere of spontaneously responsive activity as this, instead of one person first acting individually and independently of an other, and then the second replying, by acting individually and independently of the first, we act jointly, as a *collective-we*. In other words, instead of *inter-acting*, we *intra-act*, i.e., we act *from within* a dialogic situation, and 'it' is a crucial influence in how we act; and we do this bodily, in a 'living' way, spontaneously, without us having first 'to work out' how to respond to each other.

As a result, in such a form of activity as this, both the surrounding circumstances and other people's actions are just as much a formative influence in what we do as anything within ourselves; people are not so much acting 'out of' any of their own inner plans, or scripts, or suchlike, as 'into' a situation or circumstance already partially shaped by previous *talk intratwined activities* of others. This means that when someone acts, their activity cannot be accounted as wholly their own activity – for a person's acts are, among other influences, partly 'shaped' by the acts of the others around them – this is what makes joint actions, dialogical *intra-actions* so special: they are continuously creative of new responses, both to their circumstances and to each other.

To the extent that the overall outcome of a joint action is not up to any of the individuals concerned in it, its outcomes can seem to have 'come out of the blue'. Yet, because the people involved in it must respond intelligibly to each other, it is nonetheless 'structured'; it has what might be called a 'grammar'; it 'invites' only a limited domain of next possible actions.

In other words, those involved in such joint action, *create* unique, novel, circumstantially appropriate 'situations' between themselves, which, although they may contain no independently existing material *objects* as such at all, it is just as if they did – hence the ethical force of such 'things' as *commitments* and *promises*.

For those within a 'situation' feel required to conform to the 'things' within it, not because of their material shape, but because we all call upon each other, ethically, to recognize and respect what exists 'between' us. Thus, as neither 'mine' nor 'your's', the 'situation' itself constitutes something to which we can both contribute: it is 'ours'.

A person to speaking *monologically* is saying in effect: "Instead of us all living in a reality of *our own* making, all the rest of you must live in *my* reality!"

2) *Utterances*: As Bakhtin (1986) sees it,

"all real and integral understanding is actively responsive, and constitutes nothing other than the initial preparatory stage of a response (in whatever form it may be actualized). And the speaker himself is oriented precisely toward such an actively responsive understanding. He does not expect passive understanding that, so to speak, only duplicates his or her own idea in someone else's mind" (p.69).

Indeed, utterances are, we can say, the formative units of situations (and, as I see it, of joint action also). In studying utterances rather than grammatically well-formed sentences, Bakhtin claims that the utterance is a real responsive-intra-active unit for at least the following three major reasons:

(i) It marks out the boundaries (or the gaps) in the speech flow between different speakers, in that "the first and foremost criterion for the finalization of an utterance is the

possibility of responding to it..." (Bakhtin, 1986, p.76).

(ii) And because every utterance (even an utterance apparently 'opening' a conversation) in its performance must take into account the (already linguistically shaped) context into which it must be directed. For "any concrete utterance is a link in the chain of speech communication of a particular sphere... Therefore, each kind of utterance is filled with various kinds of responsive reactions to other utterances of the given sphere of speech communication (Bakhtin, 1986, p.91).

(iii) And because the very 'bridging' of the 'gap' between the ending of an utterance and the response to it, forms a *living* (and not a merely mechanical) relationship of some kind. For example: If we take two sentences 'Life is good' and 'Life is not good', one is simply the *logical negation* of the other; there are no dialogical relations between them. However, when issuing from different voices in a dialogue, the second utterance voices *disagreement* with the first – a relation with quite a different evaluative sense (responsive understanding) to it is jointly created. The practical meaning of words in their use is not something simply felt or experienced in isolation, their meaning is responsively understood, in terms of the dialogical relations they create in the responses they call out in others in a particular situation.

3) *Speech genres*: Speakers, in taking into account all the

"various kinds of responsive reactions to other utterances of the given sphere of speech communication" in the voicing of their utterances, clearly cannot just speak as they please. Indeed, as we have already seen, our utterances are "constructed between two social organized persons, and in the absence of a real addressee, an addressee is presupposed in the person, so to speak, of a normal representative of the social group to which the speaker belongs... Each person's inner world and thought has its stabilized *social audience* that comprises the environment in which reasons, motives, values, and so on are fashioned" (Bakhtin, 1986, pp.86-86).

Thus whatever we say can never be wholly up to us – all our utterances are to an extent jointly produced outcomes between ourselves and others. Yet, our utterances are not responsive to just anyone. In being directed toward a stabilized social audience, have their being within a particular "form of life," and to that extent, they have a generic form, or, they belong to a *speech genre* (Bakhtin, 1986). Where, what it is that makes a set of utterances all hang together as members of a genre, is that

"each speech genre in each area of speech communication has its own typical conception of the addressee, and this defines its as a genre" (p.95).

In other words, it is our actual or imagined ways of relating ourselves to each other – what, as we have seen, Wittgenstein calls our "forms of life" – that are the basis for our ways of talking, which ultimately provide us with our ways of thinking. These are the constraints we must take into account and struggle with in attempting to answer for ourselves; we cannot just respond as we please.

Taking all these emphases together – upon joint action, the nature of the utterance, and their embedding in speech genres – we can perhaps begin to see why the gaps in the speech situation, our relational encounters, are so important to us. For it is in those gaps, in these momentary relational encounters, that everything of importance to us – especially politically and ethically – exerts its influence. These influences work in the gap or on the boundary between the ending of one utterance and the next that is a response to it. It is in these moments of indeterminacy, that the influences of others (or the Otherness of one's circumstances) can partially at least determine the 'shape' of the 'doings' of individual agents.

This is why, in this approach, we are far less interested in patterns of 'already spoken words', and much more interested in the moment by moment emergence of 'words in their speaking': for it is in our responsive speaking of our words, that we can begin to *create* with others, *in joint action*, a sense of

the unique nature of our own inner lives – to the extent, that is, that they are prepared to play a proper responsive part in the process also. And it is in our utterly unique and novel uses of language also, we can offer or afford others a responsive understanding of our own unique inner lives. We cannot, ahead of time, know precisely what it is we need to say in expressing our needs and desires to others. We need their expressive-responsive listening as we speak, if we are to continue our speaking with them, otherwise, we have to re-trace our steps and try to express them in other words.

**Our conjoint spontaneous involvements,
and the relational opportunities they afford for our self-determination as free agents**

Goffman (1967) discusses the spontaneously emergent “involvement obligations” and other responsibilities we face in sustaining such joint spontaneous involvements, along with some of the “involvement offences” we can commit by becoming too wilful in our actions. As he notes: “A conversation has a life of its own and makes demands on its own behalf” (p.113). Thus, our involvement offences almost all arise out of us acting deliberately, as we ourselves require, rather than spontaneously, as each conversational moment requires. In the next section below, I will turn to a discussion of these essentially ethical issues. But here, I want to discuss the *existential* character of the conversational realities that are created between us in our joint spontaneous involvements, and how we depend on these realities for feeling secure within ourselves, as well as what happens to our self-assurance if fail to sustain them.

Goffman (1967) describes this existential aspect of our involvements thus: “Social encounters differ a great deal in the importance that participants give to them but... all encounters represent occasions when the individual can become spontaneously involved in the proceedings and derive from this a firm sense of reality. And this kind of feeling is not a trivial thing, regardless of the package in which it comes. When an incident occurs and spontaneous involvement is threatened, then reality is threatened. Unless the disturbance is checked, unless the *intra*-actants regain their proper involvement, the illusion of reality will be shattered, the minute social system that is brought into being with each encounter will be disorganized, and the participants will feel unruléd, unreal, and anomic” (p.135).

We depend on the others around us, then, if we are *to use words* to expressing ourselves to them. Without what we might call their “anticipated answerability,” we can feel quite impotent to express our true and unique selves *in words* to them – no matter what we say of ourselves, we feel they will not be able to recognize in the subtle dynamics of our utterances as they unfold, the dimensions of *our* otherness, our *expressions* of ourselves. Bakhtin (1981) puts the issue thus:

“Every word is directed toward an *answer* and cannot escape the profound influence of the answering word that it anticipates. The word in living conversation is directly, blatantly, oriented toward a future answer-word; it provokes an answer, anticipates it and structures itself in the answer’s direction. Forming itself in an atmosphere of the already spoken, the word is at the same time determined by that which has not yet been said but which is needed and in fact anticipated by the answering word” (p.280).

Thus all speech must in its ‘contours’, so to speak, be uniquely responsive to its circumstances – to the characteristics of the speaker, the addressee (the listener), the surrounding situation, and so on – if it is to be expressive of the unique circumstances of its occurrence. Thus we cannot, unless we are uttering the mere formulaic repetition of a fact, issuing an official command, or expressing some other entirely conventional utterance, simply utter a sequence of pre-decided words. For, to emphasize the seemingly paradoxical point already made above yet again, we cannot know ahead of time exactly what words we need to utter to achieve our desires. The ‘something’ we desire, the ‘lack’ we are trying to remedy, cannot already be known to us in its practicalities, i.e., *its* character, in *these* circumstances. We must – with the aid of the others around us – search to discover, step-by-step, what it is that will satisfy the impulse to act we feel. Hence Wittgenstein’s (1953) remark: “Let the use of words teach you their meaning. (Similarly one can often say in mathematics: let the *proof* teach you *what* was being proved.)” (p.220).

For the process of discovery here, then, paradoxical though it may again sound, is not at all akin to the process in which we discover 'a solution to a problem' – a bottom-up process in which we 'work out' a particular unknown quantity by discovering its relationship, its 'place', within a system of quantities already known to us.

Our trouble in having others understand us is, to an extent, *indeterminate*. It can begin with their spontaneous reactions to our actions or utterances¹, but then must proceed in an open, top-down process, within which an overall, shared form of life has to be creatively developed between us, step-by-step, in a transaction negotiated between them and ourselves. And only the final achievement of a mutual understanding will allow us, retrospectively, to identify what the particular steps were – among the many other inadequate steps we in fact took – that were adequate to that task. The part played by each of the particular steps we took, our elementary actions, can thus only be understood within the ongoing context of that overall activity. Indeed, to the extent that the negotiated transaction unfolds in a sequence of unique, moment-by-moment exchanges, each one having, so to speak, both a unique direction and sense², our elementary actions simply cannot be 'cut-out' from the overall activity in which they are embedded, if their unique, momentary, direction and sense is to be retained – a point, as we shall see, of the utmost importance.

Involvement obligations: the rights and duties of *intra*-actants

Ethically, then, if we and our intralocutors are to communicate readily and easily, we must all rely on each other to sustain the sense of a collective-we, a shared reality between us and around us, that is *our* reality. For, it is only within such an intimately shared reality that we can not only express to each other *who* we are, the nature of our unique 'inner lives' to each other. But, to go further, it is only within such richly textured realities that we can sense ourselves as *free agents* in our intra-actions, and not feel 'dictated' to by the others around us in what we say and do. For, it is just *in the gaps* they offer us, in between their talk and our responses to it, that we can have the opportunity to act completely in terms of our own judgments and skills, to adjust our actions as we perform them to fit *our* sense of *our* circumstances.

To appreciate the importance of our being able to do this, imagine what would it be like if, even in these small gaps (through a radio ear-piece, say), the voice of another was at work in us, trying to tell us what to say next? First, we would feel disoriented and confused, with the other trying to command us to talk in ways quite unrelated to our own sensing and judging as to what was best for us in each moment, as we related ourselves to the changing nature of our circumstances. We would not know how to phrase or intone *their* utterances. How should we fit them into *our* circumstances? But secondly, our conversational partners, if they found out, would feel outraged at having been cheated, at having being misled into responding to 'our talk' as if it was *our* talk, when it was in fact the talk of another.

Indeed, it might be difficult to establish whose disturbance would be greater. But one thing is clear, such a circumstance would, besides eliciting bewilderment and confusion, would also elicit great anger and resentment, and do it almost instantly in the very moment of bewilderment. For at the very heart of our precarious living out of our lives as beings continually vulnerable to unforeseeable events in our surroundings, is our having the right to act in ways related to *our own sense of what matters to us* as the unique persons we *are*. Unless we are allowed to offer our *own sense* for our expressions, and can trust those around us to 'take up' our offers, we cannot, so to speak, 'live our own lives'.

For, unless we are allowed the right to determine our meanings in the moment, we cannot feel fully free to express ourselves. Ethically, we must allow other people both to be "specifically vague," i.e., to be only partially clear, in what they say, while allowing them to entertain the expectation that either, we will assist them in further making their meaning clear, or allow them whatever further opportunities are required for them to do so. Without these expectations, without this trust, to repeat, "participants will feel unruly, unreal, and anomic" (Goffman, 1967, p.135).

In our current cultural climate, in which most of our relations to the others around us are of a technical or functional nature, it is not difficult to feel humiliated and reduced, treated disrespectfully (Sennett, 2003; Shotter, 2004). But just sometimes, even in our meetings with strangers, we can suddenly feel recognized and find a special feeling of 'in-touchness', of responsive-relatedness, at work within our intra-actions with that other. But if that feeling collapses, then it is quite easy for us to feel unheard, or unable to express ourselves. Is there something wrong with us?

A relevant event here is recounted in Anderson and Goolishian (1993). It is a psychotherapeutic encounter between Harry Goolishian (a family therapist) and a thirty-year old man, Bill, a so-called 'revolving door treatment failure', who has been hospitalized on many previous occasions as a supposed paranoid schizophrenic. Goolishian asks him: "What, if anything, could your previous therapists have done differently that would have been more useful to you?" Bill immediately answers: "That is an interesting and complicated question. If a person like you had found a way to talk with me when I was first going crazy... at all the times of my delusion that I was a grand military figure... I knew this [delusion] was a way that I was trying to tell myself that I could overcome my panic and fear... Rather than talk with me about this, my doctors would always ask me what I called conditional questions" (p.25) – what Bill called "conditional questions" were, of course, check-list diagnostic questions, questions which had the intra-actional effect of making Bill *feel* like an object under another person's surveillance. Whereas, Harry Goolishian was *there, present*, in a personal relationship *with him*, rather than, so to speak, *standing over against him*, observing him from a distance.

In other words, Harry Goolishian's response was an *acknowledgment* of Bill's expressions of himself a person of value, worthy of being listened to and taken seriously. Clearly, Bill was immediately able to recognize that something special was underway, that had not been present in the previous psychiatric interviews he had undergone. But what was it that enabled Bill to tell so immediately that his relationship with Harry Goolishian was so different from his previous relationships with psychiatrists and psychotherapists? How was it that Bill felt able to go on almost straightaway after beginning to talk with Harry Goolishian, to say: "If you could have talked *with* the 'me' that knew how frightened I was [as you are talking *with* me now]. If you had been able to understand how crazy I had to be so that I could be strong enough to deal with this life threatening fear... then *we* could have handled that crazy general" (p.25, my emphasis and additions)? Instead of putting Bill in the one-down position of a 'testee', being examined as to whether he could 'pass' the questions asked him, Goolishian was putting himself in the position of 'tutee', asking Bill to 'teach' him. Suddenly, who may not be an expert on normally required behavior, but is an expert on his own problems of coping with life, has much to say.

Just as we can all immediately detect (Bill included) – when, say, someone we are talking with at a party ceases to be 'with us', so to speak, and to look over our shoulder for their next port of call – the disappearance of the spontaneous living interplay of mutual expressive responsiveness occurring between ourselves and others, so we can also detect its, in various degrees, its presence. Indeed, we can sometimes find it inappropriately excessive, so that the bank teller's pauses, glances, and smiles can only mean that they are using the current financial transaction between us as the vehicle for a 'flirtation' of some kind. Indeed, this interplay in some degree is in fact a *required background* to all our intra-actions, if we are to have any success at all in being meaningful to each other within them.

As the examples above show, however, we have tended not to attribute much importance to these subtleties, these niceties of our conversational intra-actions. We have tended to focus instead – like the questionnaire wielding delegates, and probably Bill's other therapists – simply on the informational, functional, or logical *content* of our utterances, while leaving their *relational style* unexamined in the background.

But as Goffman (1967) makes clear, although they may be given very little prominence in our current *efficiency-conscious* dealings with each other, stories of events that draw our attention to their importance are enshrined in our culture, and are told from time to time: "No culture, in fact, seems to be without exemplary tales for illustrating the dignity and weight that might be given to these passing realities; everywhere we find enshrined a Drake who gallantly finishes some kind of game before going

out to battle some kind of Armada, and everywhere an outlaw who is engagingly civil to those he robs and to those who hang him for it" (p.118). Indeed, although such exemplary events may currently be few and far between, I'm sure we can all remember times when, needing or wanting to leave a conversation, we have stayed involved in it until 'the right moment to leave' occurs – and in so doing, "affirm the moral rules that transform socially responsible people into people who are intra-actively responsible as well" (p.118).

Conclusions: the power of noticing (and noting 'noticings' in words)

To end this talk, let me emphasize two points already made, by repeating them in Goffman's (1967) words. First, with regard to what he called one of the fundamental aspects of social control in conversation, he notes that: "[A]s Adam Smith argued in his *Theory of the Moral Sentiments*, the individual must phrase his own concerns and feelings and interests in such a way as to make these maximally usable by the others as a source of appropriate involvement; and this major obligation of the individual *qua* intra-actant is balanced by his right to expect that others present will make some effort to stir up their sympathies and place them at his command. These two tendencies, that of the speaker to scale down his expressions and that of the listeners to scale up their interests, each in the light of the other's capacities and demands, form the bridge that people build to one another, allowing them to meet for a moment of talk in a communion of reciprocally sustained involvement. It is this spark, not the more obvious kinds of love, that lights up the world" (p.116). In other words, no matter what sentiments we might claim to adhere to in our treatment of others, *the primal scene* with respect to which outside others make their judgments of us, is to be found *there*, in the moment of our intra-action with those others.

If the account given above – of how it is possible for us to appreciate that another being has a life *of its own, not independently* of us, but *in relation* to us – is correct, then we have a chance of understanding how to conduct our everyday practical-social affairs more democratically. For, as became clear above, it is within the complex texturing of our intra-active involvements that our sense of ourselves acting as *free agents*, not in accord with the 'dictates' of others, is possible.

But teasing out the intricacies of what is involved in our having the right and being able, in appropriate moments, to act completely in terms of our own judgments and skills, to adjust our actions as we perform them to fit *our* sense of *our* circumstances, is clearly not an easy task. It is a possible task, nonetheless, once we realize that it is rooted in mutual respect and mutual obligation – not in the supposed 'objective' claims of experts, who have forgotten how they were in fact trained by their teachers (in a process rooted in mutual respect and mutual obligation) to distinguish *reality* from *illusion*. Our understandings of what reality *is*, and what it is *to be* objective, are a consequence not the cause of our obligations to and respect of others. Indeed, what Goffman (1967) confronts us with here, is not simply a difference between the *intra-actional order* and other kinds of *social order*, but with something so fundamental that without it, we cannot be ourselves. For in fact, we owe the very possibility of our having *a life of our own* to the dialogical responsiveness of *those others* toward us.

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Notes:

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1. As Wittgenstein (1980) remarks: “The origin and primitive form of the language game is a reaction; only from this can more complicated forms develop. Language - I want to say - is a refinement, ‘in the beginning was the deed’ [Goethe]” (p.31). And elsewhere that: “The primitive reaction may have been a glance or a gesture, but it may also have been a word (1953, pp.217-218).” “But what is the word ‘primitive’ meant to say here? Presumably that this sort of behavior is *pre-linguistic*: that a language-game is based *on it*, that it is the prototype of a way of thinking and not the result of thought” (1981, no.541). And it is from these beginnings, that entirely new and unique ways of ‘going on’ can be creatively developed between us.
 2. Elsewhere (Shotter, 2003), I have talked of how, by entering into dialogically-structured relations with a disorienting circumstance, we can arrive at a “shaped and vectored sense of the space of possibilities it opens up to us in the responses it ‘calls’ from us” (p.387), and thus gain a sense of how ‘to go on’ within it.

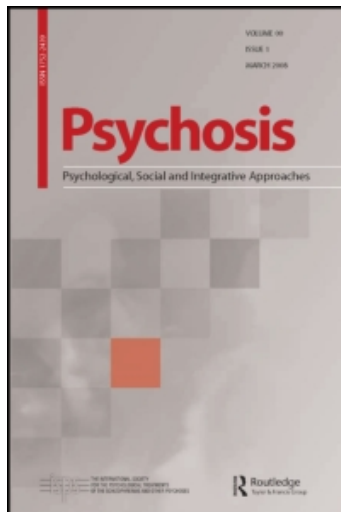
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Publisher Routledge

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Psychosis

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t777186832>

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Debra Lampshire

To cite this Article Lampshire, Debra(2009) 'Lies and lessons: Ramblings of an alleged mad woman', Psychosis, 1: 2, 178 — 184

To link to this Article: DOI: 10.1080/17522430802609992

URL: <http://dx.doi.org/10.1080/17522430802609992>

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Lies and lessons: Ramblings of an alleged mad woman

Debra Lampshire*

(Received 28 September 2008; final version received 7 November 2008)

This article is a reflection from the lived experience of psychosis while examining the factors which may have contributed to ongoing mental distress. I endeavor to articulate the processes and emotions experienced over the duration of my time as an “alleged mad woman”. I also critically analyse the bearing of past events in my life and the impact and behaviors they produced in later years. In common language I share the intimacies of “madness” and the explanations that I invoked to make sense of what was happening to me. Seeing the madness as a “coping strategy”, rather than a “bio-medical response”, I invite readers to examine the notion of “psychosis” and place the client into the role of “healer”. I also invite readers to reflect on their practice and confront their ability to share people’s distress without being overwhelmed by the desire to “fix it”. In the busy clinical environment is there sufficient time allowed for clients to tell their complete story? What are the consequences if that isn’t allowed to happen?

Keywords: engagement; experience of using services; first-person account; hearing voices; therapeutic relationship

I often wonder when it began, this ascent into madness. Was there a date, a time, a word spoken? Was it an event or place that precipitated the ascent? I have searched, but so many of my memories are untrustworthy or inaccessible that there doesn’t seem to be any recollection of a clear singular event or notion. Rather a kaleidoscope of bumps and bruises and harsh words which blend and melt into each other and depending on what perspective you take it reforms every time you view it. This collection of life circumstances have combined to guide me into a world which I felt I needed so much protection from.

One of my earliest recollections is an overwhelming feeling of not quite “fitting in”; at school, within my family and within my environment. A sense of being on the outside looking in, of watching my life being lived as an observer, rather than a participant. Over time I was to have numerous experiences which would reinforce this sense of “detachment” from others, and the more I experienced it the more I craved to experience the feeling of connection to others.

I discovered, quite by accident, that I was adopted when I was seven. I remember being consumed by an overwhelming sense of rejection. I was told the story of my adoption. I had been adopted by another family first who became concerned that I may be brain damaged when they received the medical records of my birth.

The possibility of having a child that was less than perfect when they had gone through such a process procedure was too much to endure. I was returned to the adoption agency after spending six weeks with this family. They did not bond with

*Email: debral@xtra.co.nz

me, they did not wish to have a damaged child; they did not love me enough. Now I knew that there was nothing you could be certain of in the world, there were no anchors. People could not be relied on or trusted, I discovered that people were commodities and could be disposed of at whim. My fate would always be controlled by others and their opinion and judgments of me would determine my life.

I was to learn the importance of being connected and attached to people. That it was imperative for survival, because if one didn't have that connection then one was of little or no value. I was told my adoption was a private matter and not to be discussed at anytime with anyone including my parents.

Lesson: It is alright to *live* a lie as long as the truth is kept secret.

I recall family holidays, but one in particular stays with me. The family was staying with relatives and I was invited into my uncle's bed for "cuddles". After several occasions we "got caught" and I was slapped and beaten by my aunty while she raged at my uncle. I remember being taken aside and spoken to about "touching" and "private bits", whilst instinctively knowing that that it was wrong and best for everyone to lie about this and deny anything "inappropriate" happened.

It was clear from the way the adults acted that this was what they wanted to hear and I obliged. I couldn't understand why they wished to deny me the feelings of warmth and pleasure derived from "cuddles"? I also couldn't understand that why, if I hadn't done anything wrong, I was punished, so clearly implying I had done something wrong. My parents never again looked at me the same way and I knew they could smell the badness festering inside me. I could only pretend to be good, in their eyes. I could never be good.

Lesson: It is alright to *tell* a lie as long as the truth is kept secret.

My locale didn't have a high school so I had to attend a school in another district. It wasn't until I attended this school that I discovered that my neighborhood was considered the poorest, crime-ridden, culturally diverse and therefore the least desirable area to live in. Teachers appeared to treat those of us from the "wrong side of the tracks" differently: there was always an atmosphere of possible unpredictable or explosive behavior from "those students". I recall a teacher telling me in front of the whole class that all I would ever be was "queen of the dustbins" and not to forget where I came from.

I remember the shame, but more so the knowing that he was correct, that my future was preordained and who was I to think that things could be any different for "girls like me". Fellow students wouldn't come to my home as they weren't permitted by their parents. There was nothing I could do to fit in because that was predetermined by where I lived. I was destined to be isolated and marginalized by my peers. If I wanted to fit in to make friends I had to be more like them and lie about my home address and my heritage. So I watched and observed. They were easy to impersonate, so I did. I surrendered parts of myself to become acceptable. I never got those parts back. (They were good parts.)

Lesson: It is alright to *become* a lie as long as the truth is kept secret.

I had been hearing voices for a long time, since early childhood. My first voice was maternal, kindly and nurturing; all the things one wanted from a mother, and she

helped me sleep; she was the lioness who would protect her cub. She was proud of me and she helped me make sense of difficult situations when my emotions would wash over me and my brain wouldn't work properly. In those times, when I became confused and fearful, she was my constant, my mentor, my wise, reliable, beautiful companion, the antithesis of what I had experienced of adults previously. She was mine alone, I didn't have to share her with anyone, and the best way to keep her mine was to not mention her existence to anyone.

Lesson: Keeping secrets keeps you safe

Although I loved the learning environment I didn't do that well at school – the consequences of existing in this way day-to-day started to exact a toll and cracks began to appear. My school days were marred by frequent parental trips to the school for my “behavioral issues”. Teachers were concerned by my constant emotional outbursts in class, and my restlessness and distraction to others. My parents were never called to school to discuss either my academic ability, or my potential. I was labeled a problem student and sent for a mental health assessment. This was my introduction to mental health services. This was the beginning of my vocation as a service user.

I sat in front of the psychiatrist and we spoke of private, personal things with no introduction. I was twelve, he was a hundred. He asked me embarrassing questions about sex and boys, trying to extract answers that I didn't want my parents to know about: I knew that everything I said to him would be repeated to my parents so I lied profusely.

Later when the session was discussed with my parents, they told me what he had reported back to them. I discovered that all the lies I told him, he believed; all the truths, he didn't. Maybe he was right, maybe I had got it wrong. My judgment was impaired. Once again I discovered people can't be trusted, not even myself. I concluded I could not be helped. My parents were not happy with his evaluation of my mental state so I simply did not return. The status quo remained both at home and at school and my distress compounded and accelerated.

I can still evoke the restlessness I felt. The desperation to escape, to get out, to run away, to be anywhere but where I was. Trouble was, I felt that way as soon as I reached wherever I ran too. There was no sanctuary for me, no sense of safety, the only place I did feel remotely safe was at home, because at home I was alone with no-one to cause me any problems. I didn't have to live up to people's expectations; there was no experiencing the looks of disappointment and disapproval. I didn't need to change my character or my personality to merge and blend with the people I was currently with. I could breathe at home, but I was alone. Feeling safe meant being alone. Yet I didn't wish to be alone because I knew that to be alone was to be irrelevant, that I didn't matter, and not mattering to anyone is a terrible feeling. I did so want to matter to someone; I so wanted to be loved. How do you make people love you when you can't bear to be around them?

How do you risk exposing yourself to such a risk, the ultimate risk, the risk of rejection, knowing with absolute certainty that you are not worthy of being loved? Please, don't ask me to do that. It's far too dangerous.

These were the lessons I gained as a child, and through the eyes of child, I developed childish beliefs and thought processes. They remained throughout adolescence and were deeply entrenched by adulthood. They were the filter that flavoured my taste of the world, and those who occupied it.

When my schooling concluded I embarked on a frenzy of seeking “loving” relationships but instead found unsatisfying and often demeaning ones. I married young to a person who while extraordinarily clever also experienced great difficulty in determining fact from fiction and would draw me into his imagined world, one of his, which was one of privilege and specialness. The marriage was not to last, but the visitation to the world of fantasy (named psychosis by mental health services) was to remain, and I became rather than a weaver of stories, an embroiderer. I had the ability to fill in all the gaps, to not leave out details; details are the things that catch you out when discerning the truth, but not me, this was my forte: details. This is how you become convinced of the magic, by filling in the gaps with the minute details which give it life.

My world was now one of voices of spectacular friends who were charming, clever, and witty who wanted to be around me, who enjoyed my company and sought me out every day. But these friends would turn me into their victim. The voices became nasty, critical voices; since I had opened the door to one I had inadvertently opened the door to the others. It was these voices that were to overwhelm me, these voices that would dominate; the others began to fade and finally dissipated and became almost non-existent. Only one remained, my bastion of strength, my valiant heroine from my childhood, she stayed; she ensured they wouldn’t destroy me.

This desperation I had experienced in my early days at school, in fact I can’t recall it not ever being there, this restlessness I now knew as anxiety. This pervasive, all-consuming emotion is pure unadulterated fear. To this I became a servant: fear was to be my master and it would rule with cruelty and malevolence. The tools it used were the voices. They were pawns in this game of control, a game I had long given up playing, a game I had resoundingly lost. This realm was to be my future and where I would live for eighteen years. I was governed by voices who told me lies and truths, and both were delivered with brutality and inflicted wounds that scarred me forever.

They told me, and I believed them, that I was going to receive a message from God and that this message would free the world of tyranny and bring lasting peace to the world. Because I had been chosen, these voices would test my integrity, my worthiness, my incorruptibility and would determine if I was a fitting recipient of such a message. I saw signs of my “calling” everywhere: on the television, on the radio, seemingly inconsequential events, though all were clear signs to me that I was the chosen one. I had to remain humble though. It was imperative that I keep this monumental event secret, then and only then everyone would know of my specialness. I had been picked because it was known that I was very good at *keeping* secrets. The voices taunted and tested me. I kept failing, but still they persisted: they encouraged me to be more committed and more focused on them, to be better, to be good and to be perfect. Every day was a day to prove my incompetency at almost everything. Every day I was fed more threats, more demands were made of me, and I was forced-fed huge rations of fear.

It became impossible to function, to think and to participate in the world. I needed this to stop this turmoil. When would they accept I had failed them, that I could never be what they needed me to be? Why they couldn’t just leave me alone to rot? They had got it wrong, I couldn’t be “the one”. How much clearer could it be that I couldn’t be “the one”?

I came to the conclusion that I couldn’t do this anymore. I had had enough. I was going to take my own life to bring it all to an end. Having finally made a determined and decisive move there was a fleeting moment, a tentative and fragile moment when

I took control. It was an instant, just an instant of feeling that I could bring myself back from this. It was a spark, a moment, but it was enough to ignite a flare that would allow me to take charge and orchestrate my own recovery. During those years I had been a client of mental health services. Under their care I subjugated myself to their ways, their pills and their hospitals. They witnessed my decline and told me how lucky I was to have a family that could tolerate me and that everything was just fine. They told me the lie because they believed it, and because they believed it, so did I. They told me the lie because they didn't know better.

Of all the things that I was to experience over the years it was the anxiety that proved the most destructive. With that glimmer of hope I experienced I was able to think about the here-and-now, what was going on now. I raised the question "If there was one thing in my life that I could change what would it be"? Easy! Not to feel anxious. There was our starting point, my heroine and I would address: the anxiety and that is all. We will take the beast by the tail and take it on.

That's how the journey began. I slowly exposed myself to the things that made me fearful and allowed myself to "feel anxious" for short periods of time, and then extended these periods until I was able to extract the thinking necessary to tolerate the fear. I learned that fear was something I had endured for years: its effects had become my normal mode of being. I had totally and entirely submitted myself to it. The high level of anxiety was constant and it took very little to be overpowered by it. It was this revelation that made me question the advice long given by Mental Health services: "avoid stress". Well intentioned I'm sure, but the only way to avoid stress is to not live, and that was exactly what I was doing: not living. This single notion was to prove pivotal. If one wants to live the life they choose one has to be exposed to stress and learn how to deal with it. Essentially this is the art of growing up and dealing with an adult world in an adult way; I hadn't mastered this. I lived my life fuelled by childish notions and ill-conceived beliefs.

The skill I had mastered to perfection was the skill of covering up, of concealing the madness. It takes a lot of energy but you just simply forget that you do it, and it becomes your refuge. I must say there was some solace in that, to know I could still go there if I chose. Though now the choice is not about going there, the difference now is knowing how to come back.

It was only when I felt confident in my ability to cope with the anxiety that I decided to take on the voices. I approached this based on the same principles which had enabled me to work so effectively with my anxiety. I addressed them. I didn't confront them; they were too clever for that! I realized that the voices played an important part in my life, they were my everything: confidants, tormentors who never played truant. No-one could be involved in such an abusive relationship and not become enmeshed with the abuser or the thoughts of the abuser routinely. I decided I would change my relationship with the voices – I would treat them as allies and welcome them with love and kindness. I surmised that this would hopefully disarm them and they would have to approach me quite differently. This proved an astute observation on my part and indeed my relationship with them changed.

I began to be able to filter the less desirable and make some sense of what was behind their content. I engaged the voices as friends, as if they were trying to help me, but they had very poor communication skills. It was my responsibility to interpret what they were saying into something that was helpful and useful for me. I became very proficient at this and in a short period was able to gain some relief from the negative impact of the voices. Coincidentally by reducing my stress levels the voices also

receded, so I was able to focus much more on getting my voices under control. The most startling revelation to me was discovering that the only power the voices had was the power I gave them. This allowed me to regulate the negative voices and evaluate their content and ascertain if what they were telling me was significant.

I started with the benign voices, as the common repetitive ones were easier. Based on the same ideals used from working with the benign voices, I worked on the more intrusive, intensive and unique voices until I finally honed the technique. One of the natural consequences of dealing with the voices was subtly and covertly the beliefs that supported the voices began to weaken and I was not so convinced of their accuracy. Just as I had observed that voices don't always tell the truth, I noticed that my beliefs were not necessarily reliable and I needed to give them some considered thought and often problem-solve before embarking on any action. This is a laborious process and I was not practised at it, but eventually I was to accumulate the adequate skills that it became much more intuitive.

When I did reclaim my role as a citizen on reflection, the whole process had taken approximately nine months. It is not without some gravity that I liken it to the gestation period and all the associated process of labor and birth. There were times when it felt I had emerged from a cocoon to breathe fresh air at last. A time when I could finally embrace life and the vibrancy of the world.

I have had the luxury to reflect on my experiences choosing as I do to work in mental health with others who have had similar experiences to myself. I have the opportunity to frequently discuss, analyze, assimilate and articulate the most significant and insignificant incidents in my life, but only I hope to enhance my own self-awareness for the possible benefit of others.

Those reflections have led me to the following premises:

- I was just simply being who I was I didn't know how to be different.
- Others determined that I was without reason, I never ever felt that.
- I was living on instinct so deep and so profound it never occurred to me to question it.

There are so many things that do not require explanation as a child, and the accumulations of explanations contributes in no small way to the loss of innocence and the idea of magic, which makes all things possible. When I was bored I would retreat into a world of fantasy: I would become totally immersed to the point that the fantasy became more real than the reality around me.

Mental health services do not permit such survival skills in adulthood. Adulthood strips you of the ability to break free from captivity. I have no wish to feel so captured and confined. I wish to be free to allow my mind to be creative and productive.

I am a thinker and I maintain that it was my thought processes that lead me into despair, and equally it is my thinking and changed thought processes that will lead me out. I am convinced that visionary thinking is crucial. The ability to visit a private realm in your head is an essential, even natural part of thinking. An innate problem-solving gift we are all given if we choose to use it. Perhaps it takes us deeper into our psyche, into parts of the mind that allow us to see problems from a different perspective and to solve them in novel and imaginative ways.

There is some pain which is too great, too awful, too distressing to even contemplate to revisit. It is a pain from so deep inside that a mere brush with it paralyses you. It is too painful for tears, too painful to understand, and to keep it suppressed is to deny its

very existence. The question is raised: is it not unreasonable to compensate by allowing ourselves to be transported to another tolerable position?

The need to escape is not confined to mad people; all of us at some stage in our lives have craved to be invisible, to disappear, whether to a tropical island or a castle, or mountainous forest. I consider my madness a reasonable and rational response to situations and events that I was ill-equipped to deal with. I have learnt that there is no comparison to real affection from real people; nothing competes with the pleasure derived from personal relationships, being liked and even loved. The real risk is not trying. The fear of rejection, criticism, even possible harm and the feeling of being defenseless can exclude people from the very things that will improve their lives. These things can be overcome by accessing the resilience and courage that service users have in abundance and so infrequently gets acknowledged or sought out.

The truth does not free you from lies when that truth is defined by those who were not told the lies. I choose to believe what is most helpful to me. It does not matter if the information is a truth or a lie: what matters is how I choose to interpret it. All information can be construed as truth or lies. My role is to decide which is the most beneficial to me, which causes me the least distress, and which allows me to function in the way I wish.

I have looked for the “golden answer”, the “golden event”, the “golden incentive” so I could say “this is it”, because that is what services want: the proverbial “golden cure”. I wonder if my readers have endeavored to unearth from my writings the “cure”, hoping I would divulge a key issue or provide an “insight” into retrieving sanity. I have purposely not revealed my “secrets”: my wish is to share my thoughts and not to be analysed nor pathologized, but to be listened to.

If you can listen to my complete tale and allow me to tell it without casting your own interpretation upon it, every clue and every nuance is there. Discerning the meaning behind my circumstances is a gift consciously and generously shared, and by having someone in your corner to share the burden, together we may free ourselves of the shackles.

I give warning that searching for the cure is the greatest deception of all, for the search is an internal one. One of reconnecting to the self, discovering that you are entitled to be, and if you don't like that self, then it is your choice to change things. I am talking about a change in attitude, a completely new way of being, accomplishable when you're resolute; this is life's journey, not the journey of madness.

This is the on-going struggle of human beings.

A car's speed is limited only by how well it can stop. I have learnt how and when to apply the brakes; this allows me to pursue life and to grab it with both hands. The lure is there sometimes to renege on my pursuit of well-being, but I have sufficient resolve that I haul things back when I'm starting to build up a bit too much speed. The reason I choose to do this is simple: because I can. Because that is what I expect from myself.

I share with you my last life lesson:

Lesson: Lies remain a sanctuary *only* if you allow them to define your world.

Walking around the world Backwards

It's hard to say when I decided, consciously decided to turn away from the world I experienced. Reflecting back it happened in small increments just slowly turning away when faced with the storms the crisis the calamities that constituted my life. I sought refuge some protection from a world that seemed so arduous. Others seemed to be able to cope, others could manage but not me I was ill-equipped and totally disarmed. I searched for shelter some calm and found none so all I could really do was turn my body around endeavouring to protect the most vulnerable parts of me. I folded in on myself and retreated to a near foetal position when things got really bad. I maintained this stance for several years and before I knew it I had begun my journey of walking around the world backwards. My back exposed to the storms, blindly marching towards nothingness.

Embarking on such a vocation is fraught with difficulties whilst there may be some initial relief from the elements you are now condemned to react to a world that is passing you by. Because you're walking backwards it means that by the time things come into your vision they have already occurred the event has happened and all you can do is react.

You are powerless to change anything nor is there time to neither steel yourself nor plan strategies the moment has past and you have become a victim, abdicating ownership of your own purpose and spirit. Life becomes a nerve-racking vigil always on the verge of getting out of control you're constantly thrashing around in an ocean of despair, clinging to the rock of sanity, sensing that eventually you will tire then drown, you will be lost.

So why would anyone choose such a flawed strategy why would someone deliberately isolate themselves from the world. Primarily because the world I experienced was repressive it is threatening and dangerous and alarming. One reaction to repression is resistance and I resisted the world with every thought and deed. The world and I were not on speaking terms. The world keep trying to entice me back but I couldn't risk it I couldn't bear the pain the grief the loss. I found solace in madness I found refuge in mystical and magical beliefs, mysticisms isn't difficult when you survive each moment by surmounting enmity. I found respite creating a world that sang my songs and adhered to my code. I also found loneliness and alienation and a sadness so consuming only your soul can weep, it's a sadness that a reservoir could not hold the tears to be shed.

The sadness was not the worst of my encounters indeed I found it tolerable, it made sense to me I could understand where it came from its origins were not secret to me, I keep them secret from others because the cause was not socially permissible. You learn very quickly what is acceptable both behaviourally and thinking. Mine was not a permissible trauma.

It was fear the pure unadulterated terror that came from nowhere pervasive and unpredictable, that was my beast. When the creature rears its ugly head it fills every last inch of my humanity I dissolve, and am reduced to a primal being. It is a fear that suffocates reason and logic, a fear that enslaves your live force. It was a fear that some, who wore elasticised keys, attended mandatory restraint trainings, had barred windows and strategically placed alarm buttons told me, my fear was imagined and unrealistic. I learned they were a better judge of their own fears than they could ever be of mine. It was labelled anxiety I was to call it master.

There is a shame that comes from being constantly controlled by fear. With the shame came the voices: “Why don’t you just get it over with” “You don’t deserve to breathe the same air as others” “You let everyone down” “Your family would be better off without you” “You’re useless” “Get out, Get out, Get out”. The shamed know those voices. The shamed know what it is to contend with a stricken spirit, damaged and irreparable. So you pick up the shovel of despair and slowly start to bury your hope for relief, for laughter, to be loved, to be accepted, and to have a future.

There were moments of lucidity and calmness brief moments when reality muscled its way into my life it made me acknowledge those truths. Truth is a bully you see a bully I felt I should like but didn’t. I angrily denied what my inner self was telling me. I was also advised that that would be unhelpful and of no benefit. Best to ignore the messages because they weren’t real anyway.

Reflecting back it was those glimpses of reality, of known truths that where the catalyst the trigger to my resolve to quite literally turn my life around to re-enter earth's atmosphere with the distinct possibility of burning up on entry. I was prepared to take the risk because I had moments of remembering the pure joy of human touch the tenderness that's what you miss, the delight of just being. Madness deprives you of the absolute pleasure of attachments and to avoid attachments is to avoid life. There is little that can compare with the satisfaction gained from feeling connected to another human being there is no embrace more enthralling than that of a loved one. That is worth burning for, that is worth even the remotest possibility; and the possibility is sufficient to keep me going, I do not require the guarantee.

The capacity of humans to adapt to almost any situation and see it as normal is the reason we have found ourselves the dominant creatures on earth. Our ability to endure in the most inhospitable environments is testament to our determination to flourish. Hence when faced with extraordinary stress we develop coping strategies which become survival techniques, survival techniques become skills, skills acquired by those who wish to survive.

It is necessary to develop and hone these skills to become part of the elite, survivors in a hostile environment. Coping techniques get converted into habits. Habits that we believe keep us alive. We become reluctant to abandon our ways of survival. Even if they become detrimental to us what option if I wish to sustain myself do I have!

I have always found the use of metaphors useful it appeals to my particular thinking style and speaks to the individual's unique language. Vast amounts of information is accumulated and referenced in very short periods this is a enjoyable process when all you have time to do is think! Metaphors are endearing and fathomable an unthreatening way to disclose and evaluate information. The metaphor for my existence was being at war I experienced an unexpressed rage that had no outlet, no way of dispersing no way of being mitigated. It was a civil war my enemy sought refuge in my being how do you destroy the enemy without destroying the host that was my dilemma.

I found a way!

Wars are won by tactics superior knowledge of the environment even greater knowledge of the enemy and its capabilities and deficiencies. I read that an average-sized adult contains no less than 7×10^{18} joules of potential energy, enough to explode with the force of thirty very large hydrogen bombs. This is the kind of energy trapped within our modest frames. That's quite an arsenal at my disposal all I had to discover was how to access it. I was powerful I was strong the greatest deception of myself was not believing that. I would start with the small weapons than it would be onto the full sized artillery. My small weapon was my brain. If I had thought myself into this predicament then I could think my way out right!

Brain engaged Mind focused!

We get a choice about who we and what we fight for I decided to fight for me for my existence. I also decided not to fight against them. I would be pro me but not anti them. I decided I would not exile my tormentors I would embrace them and shower them with the one medicine known to be all healing the power of love and acceptance. I would offer them the world I so craved maybe just maybe they wanted that world too.

As in any conflict factions want to maintain their own identity not dissolve and emerge into one.

What I needed was to win a few of the smaller skirmishes to gain the confidence to ensure I was on the right path. I did and I was.

I would allow them to be I would just govern them that's when I would bring out the big guns that's when I would release my mind on them. You want to talk power house let's talk about the mind not the brain. Interdependent yes collaborative yes transcendent and exceptional, manufacturer of reality the mind has it all, the brain is the servant the mind is the master.

I spent so much time entertaining, listening, complying with what my voices said and being controlled by my beliefs I invested all my energy into dealing with the blaze I witnessed, that I quickly become engulfed by the inferno coming from behind. No more! My energy would go into me getting to familiarise myself with who I was and what I intended to be. I would redefine ordinary to include my traits, instead of excluding them. I would consider my potential to be an ordinary person living in an extraordinary world.

That sounded like bliss to me. Not being separate, not being lost, and not being alone.

I had to stop dreaming about changing my world and begin the task of it. That involved taking responsibility for my actions my thoughts and my day to day pursuits. We have all had crystallizing moments in our lives when suddenly everything begins to come together. Mine was when I discovered that the only power the voices had was the power I gave them. It was liberating and intense and woeful. All that I had endured all that I had been through and put my family through was sanctioned by me. I had unwittingly sponsored my own demise fortified it and permitted it to divest me of a universe of possibilities. It would appear the self-loathing was justified the rage against myself valid the transgressions unforgivable, but I must if I was truly to succeed I must bestow forgiveness on myself rather than berate myself for what I had done I must congratulate myself for where I was heading, but more than that I had to believe truly believe I deserved this ordinary life.

This was no time to be gorging on negativity and guilt this was a time to be pro-active to work at a sustainable level to salvage the best parts of me and cultivate what I needed to obtain a life worth living. To bring a halt to this slow death and start to live an urgent live.

I had taken the advice I absorbed the knowledge imparted when others told me what my problem was and what I had to do. I took the pills, I made the moccasins I attended the one on one session and the group session but nothing changed for me. For 18 years my mental state deteriorated but that was ok. I was considered safe. Safe from what I ask you. I listened I integrated the convictions of others. I tried to live the life others expected of me. It shouldn't have been hard their expectations were pretty low. I managed to achieve some things but not all. What I dared to do though was I dared to raise those expectation I wanted so much more than people said I would ever have. I believed I was capable of better things but I was to have these aspirations extinguished. I was told I was someone who couldn't handle slight stressors so I must expose myself to as few stressors as possible.

Do you know what happens when you do when others try to protect you from the world everyone else lives in it makes you 'them' it also makes you more vulnerable to lives events to the point where any incident becomes almost intolerable. What gets created is a passive recipient of services. If Recovery is about anything it is about being pro-active. If I want my life to be different it is me who needs to make the changes it is me that has to find the way which is most effective for me. I have to take charge and commit to the process and my own well-being.

You may sense at this point that I am about to deliver up to you some noteworthy recommendations when working with the beast. It is not my intention to do so what I wanted was to share my experiences. I have used emotive language I have used a lot of imagery I have hoped to capture your own sense of what it may have been like for me. What purpose does that serve you may ask. I did this because I don't want you to claim and solve my problems or difficulties for me. I want you to work with me so I can solve my own. To learn that I have the capacity to influence my thinking my feelings and that even the worst circumstances can produce snippets of unimagined courage.

It has often been commented on that I demonstrated a lot of courage in my approach. My supporters certainly acknowledged that, but what was not acknowledged was perhaps the courage of those supporters who allowed me to not only determine the path but to cement it. Those who refused to let past fiascos sway their own responses to me but with little trepidation sailed these uncharted waters with me. Were they naive, foolish, unrealistic even incompetent. They were none of those things they exposed me to their own faith and trust in me. They galvanised me with every success came more confidence with every failure a learning. Those heroic people they never lost hope for me they never gave up they never knew where it would end up. They just knew it was worth the effort.

They helped me turn my life around I didn't do this in isolation I didn't have tremendous resources or even resolve what I didn't have was a choice. I could choose a dormant insubstantial life or I could choose to have a life worth living. I chose the latter. So now I walk facing the sun basking in the knowledge that this is what it is to lead an ordinary life. I choose this for myself everyday.

Do you want to know the best thing about facing the world walking headlong into the future? The absolute best thing is not stepping into dog poo!!!!

Bombarded

A phenomenological hermeneutical method for researching lived experience

Anders Lindseth¹ PhD (Professor) and Astrid Norberg² RN, PhD (Professor)

¹Center for Practical Knowledge, Bodø Regional University, Norway and ²Department of Nursing, Umeå University, Umeå, Sweden

Scand J Caring Sci; 2004; 18; 145–153

A phenomenological hermeneutical method for researching lived experience

This study describes a phenomenological hermeneutical method for interpreting interview texts inspired by the theory of interpretation presented by Paul Ricoeur. Narrative interviews are transcribed. A naïve understanding of the text is formulated from an initial reading. The text is then divided into meaning units that are condensed and abstracted to form sub-themes, themes and possibly main themes, which are compared with the naïve understanding for validation. Lastly the text is again read as a whole, the naïve understanding and the themes are reflected on in

relation to the literature about the meaning of lived experience and a comprehensive understanding is formulated. The comprehensive understanding discloses new possibilities for being in the world. This world can be described as the prefigured life world of the interviewees as configured in the interview and refigured first in the researcher's interpretation and second in the interpretation of the readers of the research report. This may help the readers refigure their own life.

Keywords: phenomenological hermeneutics, interview, lived experience, method, text.

Submitted 14 July 2003, Accepted 8 January 2004

Researching lived ethics

From time to time nurses and physicians experience ethically difficult situations in the care work. They are able to talk about them, but they are not usually able to explain their ethical thinking. This is connected with the fact that human beings live and act out of their morals, i.e. internalized norms, values and attitudes, without necessarily knowing about them. For this reason you cannot just ask people what morals they have. Often they will not be able to answer. So if you want to investigate the morals of physicians and nurses, the object of investigation is not just openly there, ready to be observed. To gain access to this 'object', you may ask the nurses and physicians to tell stories about situations involving regrettable conduct, something they have done themselves, actions they have participated in or witnessed. This question will lead to exciting stories (1, 2). The situation related often happened years previously, but the interviewee may have talked very little about it. Sometimes, the telling is accompanied by tears. Thus it is possible to collect an interesting material that reveals the morals and the ethical thinking of physicians and nurses, but of course, these morals are not

explicitly spelled out. So the challenge for the researcher is to analyse the material and make the morals and the ethical thinking visible.

Searching for a suitable method

In 1989 we decided to investigate how nurses and physicians reason in ethically difficult care situations. We wanted to do research within the field of ethics. Ethics in this context means moral theory, i.e. a perspective on morals, or a moral teaching. Morals then signify the internalized norms, values, principles and attitudes we live by in relation to other people, but do not necessarily reflect on to any extent.

The big challenge we had was to find a way to investigate the morals and the ethical thinking of nurses and physicians. We needed a research method suitable for our task. This method did not exist in a ready-made form we felt comfortable to adopt, so we had to develop the method. By doing this, we had to draw on the tradition of western philosophy, which, since the old Greeks, has been occupied with the problem of understanding, not only what is good and bad, but all kinds of phenomena. We could especially draw on the tradition of hermeneutics, i.e. the tradition of text interpretation, as it first emerged in protestant theology and then became a powerful tradition within philosophy and human studies, thanks to the works of Friedrich Schleiermacher, Wilhelm Dilthey, Martin

Correspondence to:

Prof. A. Lindseth, Center for Practical Knowledge, Bodø Regional University, Norway.

E-mail: anders.lindseth@hibo.no

Heidegger, Hans-Georg Gadamer, Paul Ricoeur and others. We could also draw on the tradition of phenomenology, as it was developed by its founder Edmund Husserl and his successors. And, of course, we were inspired by the many qualitative research methods developed during the last decades. However, these methods are often preoccupied with so-called qualitative data, whereas our task was to elucidate essential meaning as it is lived in human experience. Therefore the traditions of hermeneutics, phenomenology and phenomenological hermeneutics became so important to us.

In this paper we present the method we developed. It is a phenomenological hermeneutical method to be applied in healthcare research and in human studies, and we shall explain below its theoretical foundation and how it goes.

A phenomenological hermeneutical method

The morals and the ethical thinking of nurses and physicians came to expression in narrative interviews, which were tape-recorded as well as written down, thus producing texts that could be interpreted. Therefore the research method needed had to be *hermeneutical*, i.e. a method based on text interpretation. However, we call the method we developed *phenomenological hermeneutical*. Why phenomenological?

When nurses and physicians talk about ethically difficult situations and incidents in healthcare, they are themselves interested in the ethics of these situations and incidents. They are questioning what is good and bad. As researchers we also want to understand this good and bad. It is not our task to describe and explain morals as a social phenomenon, but to understand the experiences of good and bad expressed in the interview texts. The interviews are about this specific good and bad. It is not the texts that are the subject matter to be investigated, but the ethics expressed in them, the good that may be absent.

'To understand a text is to follow its movement from sense to reference: from what it says, to what it talks about' (3). The 'reference' of a phenomenological study is not some object outside the realm of meaning, but the essence of the meaning itself. When the interviewees give expression to their lived experiences of ethically difficult situations in healthcare, the researcher does not want to seize on these experiences as something 'factual', as psychic, social or historical events that need explanation. As phenomenologists we want to focus on the understandable meaning of these experiences. When the interviewees experience actions, attitudes, relations or other human matters as ethically good or bad, we want to understand this good as the essential meaning of ethically good phenomena (or the essential meaning missing in ethically bad phenomena).

Emphasis on essential meaning

When Edmund Husserl (4) founded phenomenology about 100 years ago, his starting point was the experience that science was preoccupied with explaining natural objects or events, whereas the understandable meaning of these objects and events was taken for granted within the framework of natural research and received little attention. When, for example, a biologist investigates trees, they are objects to be scientifically explained, and their meaning, with which we are familiar in lived experience, needs no particular attention. Even mathematics, as a stream of mental events, was regarded as an object susceptible to natural explanation: How must the brain and psyche function to conclude that 2 added to 3 give 5? Husserl was a mathematician before he became a philosopher, and it was obvious to him that mathematics is about understandable meaning. The mathematician understands that in every single case of adding 2 and 3 the answer must be 5 and explanations of the functioning of brain, psyche, mind or intellectual behaviour are of little interest to him as a mathematician. If you investigate intellectual behaviour and collect evidence for the hypothesis that people will state that $2 + 3 = 5$, the arithmetic mean of all collected evidence will certainly not be 5, but may be 4.978, due to the fact that some people cannot master calculation. Such evidence-based research has no contribution to make to mathematics. Mathematics is not a science based on collected evidence for (or against) explanatory hypotheses, but a science expressing mathematical experience as lived experience, i.e. an experience from within, not from without, an experience of a logical coherence constituting meaning.

As mathematicians develop mathematics similarly phenomenologists develop phenomenology. The starting point is lived experience. Within this experience we are already familiar with the meaning of all kinds of phenomena. Take the phenomenon of a chair. As human beings we live in a world with chairs and we know the meaning of a chair, but normally, in our *natural attitude*, as Husserl (5) says, we already know about chairs in such a way that the meaning is taken for granted. To become phenomenologists we have to dispense with this 'taking for granted' and strive for a *phenomenological attitude* in which the phenomenon, e.g. the chair, is allowed to appear to the mind in its meaning structure. Having come to this meaning, we may ask for its typical or essential traits. What makes the chair a chair? What constitutes a chair as a chair? Observing the chair in our intuition, what characteristic must be retained in order for it to remain a chair? By raising and answering such questions we are able to investigate and discover what is invariable in all the variations of the phenomenon, i.e. its essential meaning, its 'essence'.

Phenomenological hermeneutics

Essences are not ideal things, given in a world of ideas, ready to be grasped in our thinking. They are essential meanings. We have to assume the existence of such essential meanings, as long as communication refers to a common world. Meaningful communication about chairs implies a common understanding of the phenomenon of chair. It implies an essential meaning we must all be familiar with in order to be able to discuss chairs, but we do not have to be very conscious of this essential meaning. Regarding different kinds of caring activities and institutions, we may discuss what we mean by 'caring'. In such a discussion we do not simply state a common definition of the word (which is very difficult to achieve), we draw upon a shared familiarity with the world in which caring takes place. This familiarity makes it possible to have a qualified and nuanced discussion about the essential meaning of caring. In the same way, our experiences of consoling or being consoled make us familiar with the phenomenon of consolation in such a way that we may discuss its essential meaning. Our experiences of good and bad actions, activities, reactions and so on make us familiar with the phenomenon of ethically good human conduct, and out of this familiarity we are able to discuss how to understand the (essence of the) ethically good. Such examples, and we could give an endless list of them, tell us about an *original experience* of the world (5, *originär gebende Erfahrung*). This original experience is a basic relatedness to the world. It is not a special kind of lived experience, but rather the foundation for all lived experiences, the prerequisite that lived experience reveals a world, that it has a meaning content. Human consciousness is *intentional*, as Husserl (4) puts it. It is always about the world, an openness to the world (and of the world). Human existence is *being-in-the-world*, as Heidegger (6) states. And this world, as it reveals itself to our consciousness, Husserl (7) calls the *life world* and Heidegger (6) simply the *world*, as different from the objective, outer world.

We may very well be less optimistic than Husserl appeared to be as regards the question of how easy it is to clarify the essential meanings of phenomena. In his description, the essence of a chair is grasped through an intuition of the chair. In this intuition we state which characteristics of the chair cannot be subtracted while the chair remains a chair. However, if we look and listen to our familiarity with chairs as part of our life world, we must also consider our sitting on chairs as a process of positioning. In some chairs we are enthroned, in others we rest, in a chair at the university we teach and sitting between two chairs is always unfortunate. Such experiences are also witnesses to the essence of the phenomenon of chair. And such witnesses cannot be heard without narration. To come to the meaning of chair positioning we

have to tell stories, which express our experiences of such positioning. These stories reveal the meaning of chairs in our lives. In order to interpret the stories it is better to write them down. In other words, we have to produce texts to be able to thoroughly examine the meaning structure of chair as part of our life world – and thereby reveal the essential meaning of chair. And this will also be the case when we study other phenomena: the good, consolation, care, trust, rest – and the whole endless list of examples. Thus we see that phenomenology must be *phenomenological hermeneutics*. Essential meaning must be studied and revealed in the interpretation of text.

In stating this we (i.e. the authors of this article) place ourselves within the tradition of phenomenological hermeneutics as it was founded by Martin Heidegger and further developed in Germany by Hans-Georg Gadamer and in France by Paul Ricoeur. In this tradition (which has much in common with the philosophy of the late Ludwig Wittgenstein) it has become obvious that essential meaning is something with which humans are familiar in the practices of life, and this familiarity has to be expressed through the way of living, through actions, through narratives and through reflection. For research purposes lived experience has to be fixed in texts, which then always needs interpretation. We do not believe in 'pure' phenomenology in which essences are seen intuitively, 'uncontaminated' by interpretation. Nor are we interested in 'pure' hermeneutics, i.e. in text interpretation that does not transcend the text meaning to reveal essential traits of our life world.

Refraining from judgement through telling

In Husserl's phenomenology the shift from natural to phenomenological attitude is expressed in a rather technical and complicated way. In the tradition of phenomenological hermeneutics this shift is not so difficult to understand. The natural attitude is an attitude in which we judge – and have already made judgements – about the existence of phenomena. We already know, we conclude, we state the facts and take for granted what is meant. To shift to the phenomenological attitude we must refrain from making judgements about the factual. We must accomplish *epoché* or *bracketing*. The easiest and, so to speak, the natural way of doing this is to narrate from lived experience. Thus narrating, we naturally refrain from judging and concluding. We are not interested in stating facts, but in relating what we have experienced. Then the listener may also not judge: 'What you say is right or wrong', but rather participate in the story: 'So this you have experienced, so that is what you thought'. In the telling, both the teller and the listener take part in the narrated meaning. Then they are free to consider: what are the important themes here, the essential characteristics of the expressed meaning? When we say that bracketing is

accomplished, what exactly is put within brackets? It is of course not the preunderstanding. In that case meaning and essence would also disappear. What we put within brackets is our judgements about the factual, about what is the case, in order to become open to our own experience and to the understandable meaning implicit in this experience.

Critical understanding of discourse

Why is it important to obtain knowledge of the essential meaning of lived experience? Why is it important to obtain such knowledge within health care, and thus to develop a phenomenological hermeneutical method? One could object that understandable, inter-subjective meaning does not need clarification as long as it functions in communication. The meaning or essence of caring does not have to concern us as long as we understand each other when carrying out caring activities. Then we should concentrate on these activities and not on their meaning. This objection has a point: when action is needed, too much reflection may be inappropriate. On the other hand, when we have emerged from a demanding situation, reflection may be of crucial importance. For two interconnected reasons: (i) To be able to understand and, if necessary, to improve our own practice, we have to start with our lived experience. We have to express it to become aware of its meaning, and often this awareness itself leads to improvements. If we miss the opportunity to reflect on our own experiences, we will hardly find a way to improve our practice, even if organizational changes supposed to be beneficial are implemented. (ii) The meaning we need to reflect on is a meaning we take part in. If we work within healthcare, we participate in the meaning of healthcare as it manifests itself in many actions, activities, considerations, helping measures, institutions, buildings, technology and so on. We call such a meaning that manifests itself historically, a *discourse* (8). We may engage in discourses with enthusiasm, we may suffer under our participation in them; we may work against them or step out of them. Frequently it is not in our power as individuals to change them. Nevertheless, discourses, such as the discourse of healthcare, are continuously changing and we also take part in this process of change. For these reasons reflection on lived meaning and its essential traits is important. Without such reflection on lived meaning it is difficult to become aware of unfortunate practices we are part of. And it is impossible to implement a fruitful discussion that may change such practices and lead to discourse improvements.

Improving understanding

When we narrate out of lived experience and write down the narration, we produce an autonomous text, a text that expresses its own meaning. The narrative thus produced

has (in itself) no need of correction through a stating of facts. This, however, does not mean that the narrative is a fiction. It tells about our world, about being-in-the-world, about life world. This is not a factual world outside or lying behind the text, but rather a world in front of the text, a world revealed by the text. Through lived discourses we participate in this world – and through narratives we become aware of this participation. Narratives touch us and move us when they shed light on our lived experience of discourse participation. Thus being touched and moved may reveal the essential meaning of this participation, this being-in-the-world. Being touched and moved by essential meaning leads us to the truth, to lived truth as opposed to correctness, and it connects us to the ontological level of life world. However, this being in truth and connectedness to being must be fulfilled in understanding. Through narrating such fulfilment may begin. We have been formed by discourse and tradition (prefiguration) and by telling what moves us, our preunderstanding may be transferred into a liberating expression (configuration), an expression that opens up new possibilities in life (9, refiguration). A process of improvement in understanding may begin – a process that will need the authority of science to achieve something beneficial within the heavy traditions of discourse.

Creating a text

There are many different kinds of texts. Here we describe interview texts that are constructed in interaction between an interviewee and an interviewer. An interview occurs in a shared speech context, where both parties share an understanding of the interview situation. Furthermore the interviewer can stop and ask the interviewee to clarify what he/she has said when it is difficult to understand. Thus the speaking as an event and its meaning come close to each other (10). In writing on the other hand, the event of writing becomes separated from the meaning. The text becomes autonomous and open to anyone who can read. A tape-recorded and transcribed interview text lies closer to speech than to writing, especially if the interviewer herself/himself interprets it. It is fixated speech. The interviewee is the main author of the text and the interviewer is a co-author who has taken part in a more or less dominating way. In order to guarantee that the interviewee's voice is heard in the interview text it is essential that the interviewee feels free to relate her/his lived experience.

The most basic way to gain understanding of our own experiences is to narrate them and to listen to others' narratives. We can understand moral action when we listen to others' narratives about the way they acted in various situations. Therefore narrative interviews (11) are an appropriate method for disclosing the meaning of lived experience.

Ricoeur (9) emphasizes that we have a preunderstanding of life, which finds expression in the shape of stories. We organize our experiences so that they answer questions like: 'what', 'why', 'who', 'how', 'with whom', 'to whom' and 'for whom'. A story is a whole, which gives meaning to particular events, which give meaning to the whole story. A story constitutes a dialectic between the past, the present and the future (12). To retell an event means to bring the past into the present in order to shape the future. A story enables the listeners/readers to see their world in new ways. Therefore 'a narrative is never ethically neutral' (13). Narratives about lived experience generate visions of the good life and point to differences between good and evil (14). The world that is opened up in front of the narrative can be a fictive world but it can also be the ontological world (10).

When conducting a narrative interview the interviewer encourages the interviewee to narrate, as freely as possible, about his/her lived experience of the topic chosen. The hope is that the narrator will become engaged in her/his narrative and almost forget about the interviewer. The interviewer asks questions aimed at encouraging further narration, such as: Who? What did you feel? What happened next? Sometimes the interviewer may also encourage the narrator to reflect on his/her narrative. The resulting narrative should, as far as possible, be the narrator's own.

To make it possible to understand the interview text in relation to its context field notes are taken during the interview, i.e. arrangements, interruptions, etc. are noted.

The tape-recorded interview is listened to and the field notes are read. Then the interview is transcribed verbatim and pauses are marked by empty intervals in the text. Nonverbal and paralingual communications that seem relevant are also marked in the text, e.g. (weeps for about 5 minutes). The transcribed text is compared with the tape recording and adjusted if necessary. An example of a narrative about 'feeling at home' is given below:

I was sitting in my chair on the terrace. My chair was comfortable (long pause) and it was quiet around me, I was all alone. I took off my shoes and undid my buttons. It was very relaxing; I felt I was free to do what ever I would like. No one had any demands on me. I looked at the trees in the garden and remembered how I had climbed them as a child and how my mother had warned me about falling down (laughing). I smiled when I remembered her concern and love. They were the same trees as then. I thanked God for having given me such a happy life.

Interpreting the text

Interpreting a text means entering the hermeneutical circle. Ricoeur's phenomenological hermeneutical interpre-

tation theory was the main inspiration for opening the way into this circle by moving through the three methodological steps described below (3, 10). The advantage with this method of working is that there is a dialectic movement between understanding (a nonmethodic pole) and explanation (a methodic pole). Our method has been developed over a period of more than 10 years and has been used in several studies (e.g. 15–23).

Naïve reading

The text is read several times in order to grasp its meaning as a whole. To do this it is necessary for us to be open enough to allow the text to speak to us. We become touched and moved by it. During the naïve reading we try to switch from a natural attitude to a phenomenological attitude. The naïve understanding of the text is formulated in phenomenological language. It is regarded as a first conjecture and it has to be validated or invalidated by the subsequent structural analysis. Thus the naïve understanding guides the structural analysis. Given below is an example of the formulation of a naïve understanding of the interview text:

Feeling at home means feeling comfortable, relaxed, free from demands and alone, enjoying memories of a happy childhood. It also means enjoying contact with nature and a feeling of being loved by God.

Structural analyses

Structural analyses are the methodical instance of interpretation. There are several kinds of structural analyses. Here we describe thematic structural analysis, i.e. a way of seeking to identify and formulate themes. A theme is a thread of meaning that penetrates text parts, either all or just a few. It is seen as conveying an essential meaning of lived experience. In order to capture this meaning of lived experience we do not formulate the themes as abstract concepts, but rather as condensed descriptions. We formulate them in a way that discloses meaning.

There are several ways of performing thematic analyses (24). We can, for example, ask questions to the text and gather sections of the text that answer those questions (e.g. 25). Here we will describe the method whereby the whole text is read and divided into meaning units. A meaning unit can be part of a sentence, a sentence, several sentences, a paragraph, i.e. a piece of any length that conveys just one meaning.

When dividing the text into meaning units there will be some parts that do not seem to be about anything related to the research question, e.g. remarks about the temperature in the room and parts that contain descriptions of context etc. These text parts are taken into consideration during the analysis but may not contribute to the formulation of themes.

The meaning units are read through and reflected on against the background of the naïve understanding. Then they are condensed, i.e. the essential meaning of each meaning unit is expressed in everyday words as concisely as possible. All condensed meaning units are read through and reflected on regarding similarities and differences. They are then sorted and all condensed meaning units that are similar are further condensed and sometimes even abstracted to form sub-themes, which are assembled to themes, which are sometimes assembled into main themes.

During the structural analysis we try to view the text as objectively as possible. We decontextualize the meaning units from the text as a whole, i.e. we consider the text parts as independently as possible from their context in the text. This is possible if the meaning units are long enough to contain one essential meaning. We sometimes find that a meaning unit contains more than one essential meaning, which entails a further division.

The themes are reflected on in relation to the naïve understanding and the question is whether the themes validate or invalidate the naïve understanding. If the structural analysis invalidates the naïve understanding, the whole text is read again and a new naïve understanding is formulated and checked by a new structural analysis. We repeat this process until we feel that the naïve understanding is indeed validated through the structural analysis.

As a text is multidimensional and there are many though not infinite meanings (3) several structural analyses may be performed in order to disclose various meanings.

An example of a structural analysis of the narrative above is given in Table 1. The limited space available in the article has resulted in very short meaning units, which are a little unrealistic. We hope, however, that the idea is clear. In practice a meaning unit may contain a whole page of text.

Comprehensive understanding (interpreted whole)

The main themes, themes and sub-themes are summarized and reflected on in relation to the research question and the context of the study, i.e. the field of human life investigated. An example is given below (inspired by Ref. 26):

Being at home as narrated by Swedish people in various ages and professions was explained as consisting of the following themes (sub-themes): being connected to body (being comfortable, being relaxed); being connected to self (being in privacy, being free); being related to the memory of deceased other (being rooted, being loved); being connected to God (being grateful to God), enjoying life (being happy). The themes seem to be connected and being at home could be regarded as the main theme.

The text is read again as a whole with the naïve understanding and the validated themes in mind, and with an as open a mind as possible.

We interpret out of our preunderstanding (6) and we cannot free ourselves from our preunderstanding. We are only aware of aspects of it. Through critical reflection, we can revise, broaden and deepen our awareness. Discourse with other people and/or texts, especially with those foreign to us, can also help us become aware of the aspects of our preunderstanding, e.g. phenomena that we take for granted, such as phenomena related to our culture and past history.

We try to use our imagination and think of associations with relevant literature. This can of course only be done in relation to our acquaintance with the literature. Often we have to consult colleagues, study suggested literature and thus expand our possibilities.

When we find literature that seems appropriate for helping to revise, widen and deepen our understanding of

Table 1 Example of a structural analysis

<i>Meaning unit</i>	<i>Condensation</i>	<i>Sub-theme</i>	<i>Theme</i>
I was sitting in my chair on the terrace. My chair was comfortable	Sitting comfortably	Being comfortable	Being connected to body
And it was quiet around me, I was all alone	Being alone in quietness	Being in privacy	Being connected to self
I took off my shoes and undid my button. It was very relaxing	Relaxing through loosening clothes	Being relaxed	Being connected to body
I felt I was free to do whatever I would like	Being free to act as one chooses	Being free	Being connected to self
No one had any demands on me	Not being required to do things	Being free	Being connected to self
I looked at the trees in the garden and remembered how I had climbed them as a child	Enjoying nature and memories	Being rooted	Being connected to nature
And how my mother had warned me about falling down. I smiled when I remembered her concern and love	Remembering having been loved and cared for	Being loved	Being connected to the memory of deceased other
They were the same trees as then	Comparing present and past	Being rooted	Being connected to nature
I thanked God	Thanking God	Being grateful to God	Being connected to God
For having given me such a happy life	Being happy in life	Being happy	Enjoying life

the text, it is important to check whether its basic assumptions, such as outlook on life, are congruent with the perspective of our study. If there are differences, we must discuss how to relate to them. As this is a phenomenological hermeneutical study we think of literature about the meaning of lived experience. We do not force the literature's perspective on the interview text but let the chosen literature illuminate the interview text and interview text illuminate the chosen literature. Sometimes we need several literature texts to illuminate various aspects or parts of the interview text.

An example of choosing a literature text or texts to widen our horizon for interpretation is given below:

Zingmark, Norberg and Sandman (26) described the experience of feeling at home in people aged between 2 and 102 years based on interviews. They found that safety, rootedness, harmony, joy, privacy, togetherness, recognition, order, control, possession, nourishment, initiative, power and freedom were important aspects (themes) of feeling at home. The essence of feeling at home seemed to be feeling related to significant others, significant things, significant places, significant activities, oneself and transcendence. When Norberg, Bergsten and Lundman (27) interpreted interviews about feeling consoled, they described suffering as not feeling at home, i.e. feeling disconnected and being consoled as coming-home.

When we read these studies and the literature they refer to, we decide to try to interpret feeling at home as an experience of being consoled.

The process of interpreting the text as a whole and arriving at a comprehensive understanding is the 'nonmethodic' pole of understanding (3). It is not possible to follow strict methodological rules. Imagination is important. We again come close to the text and recontextualize it. We try to perceive it in the light of the literature text/texts chosen and also see the literature text in the light of the interview text. The focus is not on what the text says but on the possibilities of living in the world that the interview text opens up. The focus thus is more on the future than on the past. An example of interpreting a text as a whole is given below:

Based on this literature we formulate a preliminary interpretation that feeling at home means feeling connected to self (body and mind), living others, the memory of deceased others, nature, activities, things, God. We regard this experience as analogous to the experience of being consoled.

When comparing our themes and the sense of whole with this picture we can see that our results fit with the picture but this does not give a complete picture. We either give up our picture of the meaning of feeling at home as a whole or decide that we need more interviews.

Formulating the results in a phenomenological hermeneutical way

The results are formulated in everyday language as close to lived experience as possible. Everyday language emanates from elemental lived experience. When we try to express the meaning of lived experience we therefore use everyday language rather than abstract well-defined scientific language (10). Verbs are better at revealing lived experience than nouns. Thus 'feeling lonely' is a more appropriate wording than 'loneliness'.

Narrative language often involves poetic expressions. Poetic language makes the words mean as much as they can and creates mood, which reveals possible ways of being in the world and 'shows a deeper mode of belonging to reality' (28), while scientific language reduces the polysemy of language (29). Thus sometimes we use poetic expressions, metaphors or sayings in order to convey the interpreted meaning.

Using phenomenological hermeneutical interpretations

As the results of phenomenological hermeneutical investigations are about the meaning of lived experience, they can only be used to affect meaning of lived experience, i.e. as understood by the interpreter. It is not only the interpreter that interprets the text. The text also interprets the interpreter. Thus we use the results to help us and others gain insights about our world and ourselves and see our world and us in a new perspective. When our outlook on phenomena changes, our behaviour will also change. This process of applying phenomenological hermeneutical interpretations can be described as a process of appropriation. When we have gained a new perspective and insights about new possibilities to relate to ourselves and others, it is a challenge to help others to also gain new insights, e.g. by writing research reports in a way that can affect people.

Critical considerations

When performing a phenomenological hermeneutical interpretation, our aim is to disclose truths about the essential meaning of being in the life world. We do not expect to find a single fundamental truth; the whole truth can never be fully understood. We search for possible meanings in a continuous process. We move between the limits of dogmatism and scepticism (3). We avoid thinking both that we have the whole truth and that there is no truth to find. The truth is not hidden behind the text; it is disclosed in front of the text, when the interpreter meets the text (30). Here we will reflect on the challenges this effort implies.

First, as we search for ontological meaning, we want true narratives. We want the interviewees to talk

truthfully about their lived experiences. This presupposes that the interviewees are aware of their lived experiences. Sometimes interviewees may say that they do not remember, or they do not seem to understand the meaning of the questions we ask. The interviewees may not be willing or dare to narrate. They may not find the right words to express their lived experiences. Conducting a narrative interview is a delicate task, the interviewer should create a permissive climate and help the interviewee to feel free to relate, relying on the interviewer's promise of confidentiality.

As the interviewees can only understand and narrate their lived experience in relation to their preunderstanding and the interviewers can only understand the narrative in relation to their preunderstanding, there is a risk of misunderstanding. Skilful interviewers check their understanding of the narrative or elements in the narrative with the interviewees during the interview and use questions such as: What do you mean?

In order to arrive at as truthful an interpretation of the text as possible the process of interpretation must be strict. Klemm (10) argues that the most probable interpretation of a text is 'the one that makes sense of the greatest number of details as they fit into a whole and one that renders all that can be brought forth by the text'.

We understand in relation to our preunderstanding. We revise the preunderstanding while interpreting a text. When we feel a text is dead, it can be because our preunderstanding is too superficial or inappropriate, we cannot grasp essential meanings in the text. It may be necessary to broaden our preunderstanding by studying relevant literature or speaking to knowledgeable people.

A text never has only one meaning, i.e. there is not just one probable interpretation, according to Ricoeur (31). However, all possible interpretations are not equally probable to the interpreter or the community of interpreters. The internal consistency of the interpretation and the plausibility in relation to competing interpretations should be considered.

As results of phenomenological interpretation can only be used if they affect people's way of perceiving life, the way they are written about is crucial. Ricoeur (3) highlights the aspect that phenomenological hermeneutics is an argumentative discipline. Phenomenological hermeneutics as described in this article lies between art and science. We use our artistic talents to formulate the naïve understanding, our scientific talents to perform the structural analysis and our critical talents to arrive at a comprehensive understanding.

Conclusions

The phenomenological hermeneutical method of interpretation described in this article can be used for research with the aim to affect people's perception of reality and help them become aware of possibilities, i.e. alternative

ways of being in the world. It is only when the reader can make the interpretation integrated into her or his world (refiguration) that it can become productive in human life, e.g. it can be used to improve care.

Acknowledgements

The authors would like to thank Pat Shrimpton of Umeå University, for help with the language.

Author contribution

The authors collaborated on the presented method since 1990. The first part of the article was written by Anders Lindseth, the second part by Astrid Norberg.

Funding

The authors received no external funding for this work.

Ethical approval

Not applicable for this article, but ethical approval was obtained for each paper quoted in the method.

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PHILOSOPHICAL PRACTICE

Journal of the APPA

Volume 7 Number 3 November 2012

Special Issue on the 11th ICPP

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Nemo Veritatem Regit

Nobody Governs Truth

Being Ill as an Inevitable Life Topic Possibilities of Philosophical Practice in Health Care and Psychotherapy

ANDERS LINDSETH
UNIVERSITY OF NORDLAND, NORWAY

Abstract

On the way of life we necessarily experience life crises. In order to find orientation in life, Philosophical Practice as dialogical counseling can be helpful or necessary. The method of such practice can be presented in three steps. First of all, a space of attention has to be opened up in the dialogue in which the guest is listened to and able to listen anew to him- or herself. In this space a place appears to which the dialogues return and which they can examine further. And at this place there is always a certain issue at stake. Such issues we may call inevitable life topics. Being ill is an experience in life to be regarded as such an issue or topic. Especially the experience of mental illness is a big challenge because the mentally ill person so easily is banished from the common life-world.

A doctor can sometimes treat and cure, often relieve, but always console. The legendary Greek physician Hippocrates (approx. 460-370 BC) is supposed to have said this. For modern man this may sound as if consolation would just be an emergency solution; something the doctor can always fall back to if the treatment is not effective. However, there is reason to believe that Hippocrates did not mean it like that but rather wanted to stress consolation as the most important thing. He probably wanted to emphasize that consolation comes first, that the doctor can always console, that he can quite often relieve the patients' pains and that he can sometimes contribute to healing. He wanted to remind us that consolation is a prerequisite for treatment and not just a poor substitute.

What importance can Philosophical Practice have in the fields of medicine and psychotherapy? To answer this question I want to refer to the Greek idea of life as a dangerous way. I would like to understand Philosophical Practice as a reflection on our journey on life's way and try to clarify how we can proceed with this reflection. Based on that, I would like to discuss the challenges a Philosophical Practitioner faces when meeting ill and suffering people. I would like to point out that it is philosophy here that is consoling and that it is important for the effect of this consolation that the experience of being ill is recognized as an important life experience.

Keywords: *bracketing (epoché), illness, life-world, life experience, life topic, mental health, method, space of attention*

I. Dialogical Method: Encounter, Space, Place, Inevitable Life Topics

The word "method" is ancient Greek: *methodos*. It consists of the words *hodos*, meaning "way", and *meta*, what is translated with to, over, above etc. A method is a meta-way, a meta-hodos, a *methodos*.

A topic of ancient Greek poetry, especially the one of Hesiod, was the idea that life is a dangerous way. Everybody wants to achieve happiness and a good life, but hardly anyone finds it. Most people are striving for short-term gains or for immediate pleasures, for praise, glory, honour, power and wealth. They are taking the broad way, the way which can be walked most easily. While walking the broad way, you do not realize at once that it does not lead to true happiness and to a good life. In the beginning, everything seems

to be fine, but after a while you can start having the feeling that something is going wrong, that the way does not lead you to where you wanted to go and where you believed you would finally come to. By striving for pleasure, you rather become dependent than really satisfied. Honour and wealth do not guarantee good health, glory awakens envy in others, power can lead to conflicts, and money and possessions are not the same as human richness. After some time on the broad way, you can realize that there is danger ahead if you do not change direction. You reach a point where you can fear the worst, but at the same time this point on life's way is the ground for hope because now it has become possible to enter a better, a more constructive way of life. Especially when being in danger, new possibilities open up, and this ambivalent point on life's way, this place which represents a danger as well as a chance, has its own term in Greek: *krisis*. Of course, this is the same as our term crisis. Things can be pretty bad in a crisis, but there is also hope for being rescued. It is possible to overcome a crisis. In Hesiod's perspective, a crisis can imply to leave the broad way and take a narrow one. This narrow way is characterized by the will to achieve long-term goals and by the ability to endure all kinds of discomfort on the way towards these goals. That is why it is a difficult and burdensome way. It is the way only few people follow, and that is why it is a narrow way.

This topic, the difficult and burdensome way of life, is a crucial topic in Plato's philosophy. When he founds the Academy in 385 B.C., the model for all further institutions for higher education in the Western culture, his motive is to improve and to secure the way of life by means of a meta-way, a dialectical method which closer examines the way of life. For this dialectical way of reasoning, Plato used the term *methodos*—a term that until then had been completely unusual but that later in history and until today has become a crucial term in all kinds of activities, (cf. Ritter, 1980, pp. 1304f).

We cannot re-walk the way of life; we always have to go on. But we can in principle repeat the meta-way, the methodical trying out and arranging of the way of life, as often as we want to. "Methodos means 'A Way of Following'," Hans-Georg Gadamer (1993, p. 48) writes. That holds true for all methods—for methods of practical activities as well as for scientific methods. In the meta-position of reflecting and planning, we can put on trial an action or an activity and find out how to proceed; and we can do this again and again.

When taking a closer look at actions which are carried out by use of methods, that is with consideration and a plan, it becomes obvious that the methods can take very different forms. The most striking difference seems to be that some methods offer space and almost invite creation and the unexpected, whereas other methods precisely want to exclude that something new or unplanned occurs when carrying out the activity. The first kind of methods we may call "dialogical" and the second kind "monological". Production procedures are examples of monological methods that occur everywhere these days.

The method of Philosophical Practice has to be a dialogical one (see also Lindseth, 2010, and Lindseth, 2011). Because such practice presupposes an encounter between a philosopher and a person visiting the philosopher, the first step on the way will be to make a good encounter possible. Therefore, the philosopher expresses through his attitude that the guest is welcome at his place. The philosopher usually (but not necessarily) welcomes the guest in the room of his Practice and always in a space of attention in which the guest is invited to express his or her matter of concern. Who enters the room of a philosopher must feel to be welcome—especially to express himself or herself. That is why I think it is natural to call the person guest. By doing so, I intend to emphasize that he or she has come with the hope to be accepted and that I open up my attention and receive him or her with the best I have. My attitude expresses a Welcome!, which shows that the other can enjoy the protection and the privilege of a guest. And this is what this

person needs, because in the beginning (s)he cannot be sure that (s)he will be accepted with what (s)he expresses.

The philosopher demonstrates from the very beginning that the guest is welcome. When he enters the philosopher's room, it can be natural to offer him something to drink, a glass of water or a cup of tea. When the actual dialogue begins after that, the philosopher shows that he or she is now open to listen to what the guest has to say. Now it is important that the guest decides about the beginning. He plays the white pieces, says Achenbach (cf. 2010, p. 58) in an allusion to chess. The philosopher re-acts, he refers to the opening the guest chooses. That is why the philosopher does not start by asking for a problem. Such a question would already put the dialogue into a frame which might easily limit it. The guest might feel asked to present a "real" problem, a clearly expressed problem, a rather important problem, a problem which should then become the centre of discussion, and so on. But quite often it turns out that the first topic or issue of the guest is not the most important thing—regardless of whether it describes a problem or an experience, an event or a relationship. Something different and often less intended gains importance. That is why it is important for the philosopher not to begin with asking for a problem or with taking an order what the guest wants to talk about. The philosopher rather begins with an invitation: a sign that the guest can decide to express whatever he wants. For me, that is a principle of beginning a dialogue in the Philosophical Practice. But it is not a strict rule. Sometimes a philosopher can have a reason to ask for a problem or to take an "order". If the guest already remarks in the first contact that he has got a problem which needs clarification, then it might sometimes be unnatural not to focus on it. It is not only important what the philosopher does but even more what attitude he takes.

We know from our own experience what this attitude is about. We have all had the experience that we met or even visited a human being whom we wanted to tell something, but then it became clear that he was not open for what we had to say. Then we do not want to open up anymore. In case it is nothing personal we would like to talk about it will usually be rather easy to accept the other's lack of receptivity, but in case we have something really important to say we might feel it as insulting when we are not listened to. Maybe the other has given the impression to listen to us so that we have started to express ourselves, but then we realize that we do not really reach him or her with what we have to say. Then we feel hurt; we feel rejected.

We have also all had the opposite experience: we are listened to, with openness and attention for what we try to express. We encounter a human being who is interested in listening to what we have to say, and therefore it is easy for us to speak. We are invited into a space of attention in which our expression finds its voice. There, we find words for what we want to say, often striking or even surprising words. We find an open ear and thus we can listen to ourselves. That can mean that only then we realize what we are saying, that we realize what we are truly troubled with. Life which finds an expression in what has been said gains a new option to re-shape itself in the dialogue. Perhaps we say something we have already said before, maybe even many times. Then, we know what we say. However, we might know it all too good. We are actually finished before we even said it. However, when words meet an attentive listener, something happens. They gain a new relevance". We listen to them in a new way. We are somewhat infected by the listener's attention who listens to what has been said as something new. Suddenly, what has been said appears with the quality of something new. This might explain what often happens in such a dialogue, namely that both partners afterwards have a better mood than before. And this is not only because something important was touched in the dialogue but rather because one has entered a movement in which life forces have been set free. One feels livened up. This is quite the opposite of a process where you try to put what has been said into a frame of systematic theoretical knowledge, such as medicine, sociology or psychology.

Experiencing a space of attention, which can open up or close down when encountering a receptive or an unreceptive dialogue partner, is a fundamental human experience. In this encounter, which takes place in the space of the dialogue, life gets its shape. The encounter means help or obstacle for orientation on our way of life. We try to express ourselves, we dare to enter such an expression and we experience how exposed we are to the acceptance of the other, especially of those who are close to us. In this process, important conditions are shaped which make our life a happy or an unhappy one. Thus, it is an ethical demand to every one of us to accept the life expression of him who dares to express himself. K. E. Løgstrup (1997, pp. 17f) puts it the following way: "Regardless of how varied the communication between persons may be, it always involves the risk of one person daring to lay him or herself open to the other in the hope of a response. This is the essence of communication and it is the fundamental phenomenon of ethical life. Therefore, a consciousness of the resultant demand is not dependent upon a revelation, in the theological sense of the word, nor is the demand based on a more or less conscious agreement between the persons with respect to what would be mutually beneficial." The ethical demand the philosopher has to face is due to the vulnerable expressing-himself (or -herself) of the guest.

When life is at stake in a fundamental sense, each of us is confronted with the urgent question of how to take in the expression of the other. In many dialogues in different contexts of life it does not become obvious that so much is at stake. But in different contexts, in which the individual realizes in the encounter that he is holding a part of the other's life in his own hands, we cannot escape from the ethical demand which is given in and by the encounter itself. How then can we open up the space of attention in which the other is listened to and can listen to himself? This is the crucial question for Philosophical Practitioners. In other relations, it might be better to do something practical. However, I think that it is difficult to take in an expression of life which dares itself towards an encounter without allowing oneself to be touched and moved by this expression. And it is this readiness to be touched which opens up the space of attention and which allows the movement of life to develop new energies.

I would like to try to describe the proceeding in Philosophical Practice in form of some methodical steps:

Epoché

The Philosophical Practitioner opens up the space of attention by refraining from knowing in advance what the expression of his guest is or could be about.

But what are we actually doing when we refrain from knowing things in advance? The ancient sceptics recommended refraining from knowing things with certainty. If we try to find out exactly what life is about, we do not find peace of mind. To let go off such certainty and exactness, that is *epoché*. Edmund Husserl took over this term and used it for naming a decisive element or a step in his phenomenological method: If we want to find out the fundamental meaning of phenomena, we first have to put into brackets the given opinions about the phenomenon. We have to refrain from already knowing. (See also Lindseth, 2005, pp. 67-79.)

We refrain from knowing at once that the guest talks about a problem he would like to see solved. We also refrain from knowing in advance that the guest is talking about his desires or about his illness or about something else which can be fit into a field of knowledge we are experts in. Refraining from that does not mean giving up all knowledge. We should rather talk about a change of attitude. Instead of confronting the guest with the knowledge we already have, we rather take in what he expresses. We are prepared to let

the expression of the guest leave an impression on us, being unprotected, without seeking refuge in a field of knowledge in which we feel safe. We do not reject fields of knowledge, we rather do without their protection in our direct encounter with the guest. This is something he feels. If we encounter the guest with openness and receptivity, a space of attention opens up, in which the guest's expression can find its voice and in which the guest finds orientation within his narration. If we instead confront the guest with our readiness to classify what has been said into categories, explanations and models, this space is closed—or remains closed. Then expression is reduced to information, which can or cannot be useful for the counselor or helper. It then has become clear that the guest who is looking for advice and help is less competent to understand what has been said than the helper or counsellor. In Philosophical Practice, the expression would then no longer be an expression of his life which the guest can identify with, instead, the guest would rather be reduced to a carrier of information or even declared incapable to manage his own affairs. A dialogue community, in which the guest and the philosopher can meet to discuss their experiences—especially those of the guest—is subjected to a system demanding correctness and then collapses. A system has already colonized the life-world. Thus, we manage the first step of our method—refraining from knowing in advance—by allowing the guest's expression to leave an impression on us. This impression has an effect on the expression—not as a result of an active, controlling impulse but rather in the form of an invitation. (Such an effect is structutive, not causal. Cf. Falter, 2005, and Lindseth, 2008a.)

Eidetic Reduction

We lead back (Latin: *reducere* = to lead back) the guest's expression to a place which can appear as an image (Greek: *eidos* = image, appearance, form) in our impression.

In Husserl's phenomenology, *epoché* does only make sense in connection with eidetic reduction. The demand to refrain from knowing in advance what a phenomenon is has its reason in allowing it to show itself in greater vividness, so that we can examine better what the phenomenon essentially is about. *Epoché* becomes a condition of eidetic reduction, of the greater vividness in the phenomenon's appearance.

This corresponds to Philosophical Practice. If we refrain from knowing in advance what the guest's expression is all about by allowing the guest's expression to make an impression on us—unprotected by some kind of previous knowledge, so to speak—, we are doing so in order to allow the guest's narration and his fundamental topics appear more vivid and better to experience.

When the guest's expression can make an impression, something fundamental happens (just as we have described it in the first step of the method): A space of attention opens up, in which what has been said can show itself with greater clarity. It is as if speech was invited into this space so that what has been said gains a clearer form and a clearer shape. Then the guest can listen to himself in a more conscious way. This implies the option to find a new orientation in what he himself has said. It is as if the space of attention creates a place which allows orientation.

That the dialogue gains the character of a place is an experience from our dialogues in Philosophical Practice, (cf. Lindseth, 2008b). We see in front of us what the guest narrates. In our consciousness, images of what has been said are created—clear or unclear impressions of events or connections—, a kind of "landscape." Such vividness might well be explained as result of a strong imagination; just as we can see in front of us what happens in a novel. But what we experience in such a vividness has its origin not only in ourselves. We experience to become familiar with a place which we can explore together with our guest. We feel what the guest's narration is about, and in our dialogue we can find the words which make appear more clearly the world in which the guest lives and out of which he speaks. As Philosophical Practitioners,

we orientate ourselves by this place created through the dialogue, and in it the guest gets the possibility of orientating himself anew. The guest starts to see his life in a new light.

Even in the time between the dialogues we realize that the process of orientation continues. For instance, I can wake up the day after the initial dialogue, can take a shower and then I suddenly see an arm movement in front of my inner eye, or a view, and I start laughing out loud and say: exactly! What it was that has become clear to me I might not be able to describe exactly. But my readiness to further explore the place that exists in the dialogues has increased. So I often have the impression that I really get going only in my second session with a guest. And when the guest returns, I do not have to make an effort to recall what he had said because I feel like being at the same place again as the last time and can recognize again what it is about. That does not mean that everything has become visible. To stay within the metaphor of the place: I might see a way and a junction, with houses along the way, but I can only guess what is behind the corner. Now it requires time to find out what is at stake in the dialogues with my guest.

Therapists, especially when they are inexperienced, often make the mistake of wanting to know too soon what the client or patient talks about. Here, there is a high danger that the space of attention does not open up in which a place could be created which allows to find orientation in life. The danger is a double one: On the one hand, the therapist can be so involved in his own understanding that he overhears what has been said. And on the other hand, the client or patient loses the option to find himself in his own narration.

Transcendental Reduction

We want to “lead back” the guest’s expression to the issue or subject matter which is at stake: the inevitable topic of life we encounter in the place of the dialogue—and on the way of life. According to the Norwegian philosopher Hans Skjervheim (2002, p. 20f), every dialogue is a threefold one: A person A is talking to another person B, but at the same time both have to refer to the topic the dialogue is about. Not only do A and B influence the course of the dialogue, also the topic does because both A and B have to do justice to it. If they do not, the dialogue easily becomes irrational. It can then be shaped by A’s or B’s arbitrary opinions. Or it becomes a twofold dialogue, because one partner chooses the other as the topic of the dialogue. This can happen when A thinks that B has said something awkward. This also happens within the health service when a patient addresses a medical expert to find out what his problem is. Then, the patient become as source of information in the first place, not a partner in a dialogue. Such twofold dialogues can be useful, but they are no dialogical process in which both partners try to do justice to the topic which is at stake.

The most simple case of a threefold dialogue is when two persons discuss a topic they are both interested in. But the dialogue between the guest and the philosopher is also a threefold one. The topic of this dialogue is only rarely given in advance. The guest’s narration of his life and of his situation expresses a concern which is unclear at first and this therefore has to be clarified in the course of the dialogue. Thus, a topic of life is at stake which neither the guest nor the philosopher can define at his own will. That is why the dialogue has the character of an examination, an exploration of a familiar place and of a testing-out a way of life. But it is not an empirical examination in a scientific sense. This becomes clear from the following: When the guest or the philosopher thinks he knows what the issue or subject matter, the inevitable life topic of the dialogue is all about, then his understanding does not have the character of an explaining hypothesis, which can be falsified or verified by new events or new data. It rather is an insight which can express itself more or less appropriately.

Let us have a look at a (not really easy) example: A guest in my practice has told me how out of desperation and frustration she buys food which is suitable for vomiting and how she then prepares and eats the food—to experience a kind of satisfaction through vomiting. What now is at stake? In the language of science this is about bulimia, and we have empirical-scientific hypotheses (or theories) explaining bulimic behaviour. Such hypotheses (and theories) are uncertain by nature; the latest research may always modify or even reject them. If the guest however, understands that her bulimia has to do with a natural self-assertion which has been obstructed and therefore had to find an unusual outlet, this understanding is no hypothesis, but an insight.

Then the task is not to find empirical evidence which contributes to verifying or falsifying a hypothesis, but to find words and descriptions which capture the experience in an appropriate manner and thus give better orientation in life. You cannot talk about rejecting or accepting an insight after examining or testing it. Insights do not need verification (in form of positive empirical evidence), and they also cannot be falsified (as result of negative empirical evidence). This does not mean that the wording of the insight is necessarily true. Sometimes it becomes obvious that the description of it is inappropriate or unfortunate, while in the case of a possible appropriateness, we do not feel the same certainty. This corresponds to the situation in empirical testing (within the frame of so called hypothetic deductive method), in which falsification is more certain than verification. (Falsifications rely on the form of a valid logical inference, whereas verifications do not.) But when we realize that an insight has not found its best expression, then we realize it from within, out of the insight itself. It is not necessary to find proof which introduces elements to the argumentation from outside.

There are numerous examples for an inevitable topic of life. It becomes inevitable in the connections life confronts us with. So it is not surprising that Marianne Walderhaug, who is employed as philosopher in the Bjørgvin prison in Bergen, always refers to certain topics in the dialogues with the inmates: What does it mean to lead a “normal life”? What is freedom about?

A topic which comes up again and again in my practice are the problems related to the fact that we want to live in a community and in intimate relationships whereas we want to preserve independence at the same time. Another, closely related topic is commitment and love. A topic which is of special interest for me is how to live in irreconcilability. We might have an irreconcilable relationship with other human beings, but also—and maybe above all—with ourselves—or with life. Irreconcilability can be understood as a movement away from a fundamental pain, a movement which cannot succeed and therefore starts circling around itself. In how many different ways can we remain circling—and thereby arrange ourselves with the irreconcilable? How do we draw others into our irreconciled and irreconcilable circling? What does it mean to find reconciliation? I finally believe that my own practice is about finding and enabling reconciliation.

My topic of reconciliation is (almost) never a direct and explicit topic in the dialogues of my practice. The same holds true for all other inevitable life topics which can show themselves. Implicitly, the topic might be present from the very beginning, but it needs time, often more time than the dialogues can offer, to make the topic explicit and clear – and to maybe bring it to an end or to fulfilment. A life topic first of all has to be expressed within a narration. In the dialogues of my practice, it appears again and again, and slowly an astonishment about implicit life topics can unfold itself. Where does such a topic live on the guest's way of life, and how does it become predominant there? Within this frame, when time is ripe and when the guest is open, the philosopher can illuminate the topic by introducing thoughts of philosophers, theologians, poets and scientists.

Thus, the method of Philosophical Practice shall not guarantee that a fixed goal will be achieved, it shall rather allow urgent life topics to be reflected upon. Such a reflection of inevitable life topics means finding one's own way of life and at the same time a becoming-conscious of the essentials of life. Clarifying these questions of life which are methodically addressed in all practice dialogues is a task for Philosophical Practice which reaches beyond every procedure. Such a clarification has to lead to a narrative or systematic expression of life topics.

II. Philosophical Practice in the Field of Medicine and Psychotherapy

If we get ill, this illness is an inevitable topic of life. But it is not certain that we want to reflect on this topic, how it affects us in our life experience. We do not have to deal with it. We can deny and repress the illness. But we can not conjure it away as a topic on our life's way. The illness will show itself, and the experience of being ill forces itself onto us. Thus, illness is an inevitable life topic. But we often need the help of the dialogue in order to deal with it. This applies mostly to the inevitable life topics.

We like to distinguish between disease and being ill. The disease is a diagnosable condition, while being ill is rather a condition as we experience it. In English, there are different terms for these conditions: disease and illness. The latter we know from personal experience. We have all experienced being ill, but it is difficult to say what that is about. Apparently we mean by "disease" something objective, whereas "being ill" is something subjective. The following little story may illustrate in how far we see disease as something objective and measurable: A patient is about to be discharged from hospital, but an experienced nurse, due to her professional opinion, thinks that the patient is not well enough to be sent home. However, the lab results of this patient are not too bad, so his release is prepared. But then someone comes running from the lab, with a late result that is very bad. Thus, the patient has to remain in hospital for some more days. The clinical view which had realized that the patient was not well had been considered as subjective and without relevance.

Winning Back the Experience of Being Ill as an Important Life Experience

However, we experience being ill. And we experience what effects that has. What meaning can this experience have in our lives? Seen phenomenologically, the experience of being ill is one of many life experiences. Therefore, understanding the meaning of being ill is in its essence not different from understanding other life experiences, such as growing up, entering into relationships with others, falling in love, the pursuit of career, or whatever there may be. If we think of the experience of being ill, as we all know it, there are probably cases where it arrives suddenly, where it comes to us quite surprisingly and where it can be serious and dramatic. But often the illness comes not so suddenly. Often it is gradual. Before you have a diagnosable disease, you might have been plagued with something for many years, without anyone finding out what was missing. Or it could be that you live with an evil without really feeling it. You try to function "as always", maybe in top form, as if there were no problems at all. This is a complex picture. However, an illness always has a history. Even if it comes suddenly, something has happened before. Of course, it might be very difficult (if not impossible) to understand the illness in its context. The point is though that a life experience is always a historical experience. It does not present itself without context; it has a history, a development, and consequences. The experience of an illness is part of a life context; it is caused by events and actions which happened before, and it will shape the life afterwards.

Becoming ill is also experienced as humiliating. This is witnessed by language, e.g. in German where *krank* (ill) is related to *Kränkung* (humiliation). Being ill is a form of humiliation. That illness is a humiliation finds a clear expression in a rather archaic understanding of illness, where it is believed that an illness is

caused by "the evil eye" or that someone has imposed a curse on you. The offense is linked to someone humiliating you, which may make it easier to come to terms with the fate of being ill. Thus, the experience of being ill is externalized. It is removed from the life of the patient. It is linked to and explained by an external cause—a humiliating person, a witch, someone who has imposed a curse on you, someone who has thought badly of you. This way you can fix the bad out there.

One might now be tempted to claim that modern medicine has overcome all that. You do not think in such patterns anymore; that is progress. But on closer inspection it turns out that the modern understanding of disease, in which the disease is not understood and evaluated as a meaningful life experience but rather as a defect, expresses an even higher degree of externalization. Being humiliated by others is something we can experience; but a disease is placed outside of any meaningful and tangible life context. We do our best to see the root of evil "out there", in a cause outside of our life-world. And then the cause is no longer the witch or the sorcerer or the evil eye. These we could somehow integrate into our life-world. No, the cause is something really mysterious which is called "disease" and which is expected to be diagnosed, fought, and defeated. This demonstrates that modern medicine is in a fight. It is no longer the fight against witchcraft, but the fight against the disease. And in this fight it can be very important not to deal too much with the illness as an experience, because this would require to be able to become sensitive, compassionate, and maybe desperate. However, if you want to fight you can not afford too many sensitive reactions. Then you have to know what to fight, and you have to prepare yourself—with shield and sword, so to speak—and attack that what is to be fought. Thus, therefore is a challenge to modern health care, especially to nursing, not to be swept away in this fight from one's own premises, but rather to step out of this process of externalization—in order to win back the experience of being ill as an important life experience. Then it is no longer about finding a "cause" for the "disease" but rather about something that is perhaps more important: to be questioning and searching in one's own life as it presents itself to us anew in each moment.

In Philosophical Practice, the experience of being ill is an inevitable topic just as other life topics, but at the same time it represents a particular challenge. The experience of being ill is incomprehensible to a large extent. This is not only because of modern medical thinking, which reduces the experience of being ill to a subjective and emotional reaction. It is also because the experience of being ill is about opaque processes of life. But at the same time we have much to say when we have become ill. We might be desperate, we might be aggressive, on the hunt for a "solution", or we might be more reconciled with our fate. We might have the hope that the illness is a crisis that will pass by; we might have to accept that we have to go on living with permanent restrictions because of the illness; or we must recognize that we are going to die in the near future, a little earlier than we might have imagined. In any case, the question of the meaning of life becomes relevant for us. Before we got ill, we may have had a theoretical relationship to this question. Being ill however, we experience a sense of life which is difficult to put into words. If the situation is serious, we may need to say goodbye or to settle practical matters. It may be important to achieve greater clarity in close relationships, to mark boundaries, to show love. We find ourselves in a life situation which one could not prepare for. This can be terrible. But it can also be seen as an essential experience. We recognize in another way what is going on in life, what is important, what is at stake in life.

If illness becomes a topic in Philosophical Practice, it is about regaining the experience of being ill as an important life experience. Here there is a danger that we want to learn more than can be proven by the experience of being ill. We may have heard that grief results from experiencing loss, that stomach ulcers are caused by stress or bacteria, that cancer comes from the fact that feelings could never be expressed, and so on. However, such explanations are not helpful if they become conclusions—and because of that stop an astonishment and prevent us from really feeling what a restlessness says, what a sadness expresses,

what an anxiety is about. In Philosophical Practice, the challenge is to capture the wonder and the feeling. As a philosopher, I can not encourage simple explanations. Mostly it is not important to find clear answers to the questions raised by the illness. It is more important that the dialogue in which the experience of being ill is expressed can be kept open. Because then it is possible to complete an internal flight movement away from a stressful experience, which we carry with us, away from a difficult life issue, away from a life of pain.

If we ask ourselves what this pain of life is about, we can get into contact with a feeling of worthlessness, of shame, the feeling of being rejected, of not being loved. We may not really know where this feeling comes from. We might have experienced contempt in life, undervaluation, rejection, humiliation, but the feeling might now appear to us as “exaggerated”, a bit irrational, so that we do not have to take it too seriously. But if we accept this pain of life, then there is perhaps nothing in life what is as terrible as this feeling of worthlessness and shame. It is therefore not surprising if we escape in panic, away from the pain. But the pain is sitting somewhere in us, in the body, in the soul, so that we do not get away from it. Thus, we are caught in a circular motion, which is about not having to feel the pain. But if we avoid the pain, we are affected by an inner split, which prevents the pain from becoming a part of ourselves. Then we are not reconciled with ourselves and start to settle in the irreconcilable. Then we are shaped by circulating thought feelings such as envy, hatred, pride, etc. We perhaps avoid to feel a profound pain in life, but we can not prevent us from causing humiliation and pain in others.

In an illness we can experience to be shaken out of the irreconcilable. Together with the illness, our pain of life has become inevitable, too. This gives us the opportunity to end an internal flight movement. But to end this flight can be difficult. It can lead us into a despair about life experiences that are related to the pain. We might experience such despair when loved ones have died. Because in sadness we often not only mourn, we also despair about what we did not get in the relationship but had been longing for. Pure sadness is a praise of the good things we have lost. It is painful, but good. To reconcile with the despair is much harder, because this is about disappointments we have experienced, about accusations we are caught in, and these become an obstacle for mourning. The illness is also about mourning, and again a despair can prevent us from mourning—and from reconciling with our lives. Despair demands an energy of rebellion. However, when being ill we might become too weak to rebel. We no longer manage to escape from the pain, and so it becomes painful enough to lead to reconciliation—with ourselves, with our fellow human beings, with life. We might call this the mystery of reconciliation. It is also about consolation.

In the German etymological dictionary of the Brothers Grimm, we read that the German word *Trost*, i.e. comfort or consolation, has two meanings: In a recent sense, consolation is an active deed. But in an older sense consolation is a life force giving us inner support, trust, and hope. (See Grimm, 1952, p 903). In the original meaning of the word, consolation is a dimension of our life that we can call a “spontaneous expression of existence” (with Løgstrup, see 1968, pp. 92ff). Consolation is the existential power which puts us back to our feet when we are depressed, which allows us to find back to us when we have lost ourselves, which can unite us again when we are internally divided. It is not certain that a man who tries to comfort us can really give us consolation. It might be nature which gives us comfort, an evening breeze, a nice view, the smell of the woods—or a pet. But mostly we need the human encounter to find consolation. In such an encounter you can show that you listen to the other, perceive him or her, accept him or her in his or her expression, so that (s)he does not have to despair. Even with the despair we carry with us we can find reconciliation. If we do not deny and suppress the pain, we can be healed in the encounter with the other. (About the phenomenon of consolation as analysed on the basis of narrative interviews, cf. Norberg et al., 2001.)

Explanations of diseases, especially diagnoses, may help us to accept the illness and thus give us some comfort. Last but not least family members might be in need of this comfort. But at the same time, these explanations can also impede a process in which the experience of being ill is important. Explanations stating that our condition is caused by experiences of loss, stress, frustration, lack of emotional expression—or by bacteria, viruses, hormones, genes, etc. do not help us a lot with our inner reconciliation and therefore do not give us real consolation. If we realize, however, that a sadness dominates us, that our condition is related to fear and shame, that we feel depressed due to the grief over our own physical condition—then that is something else. Then sadness, fear, shame, etc. become the foundation for amazement and deeper thoughts,—for a sensitive self-reflection. This might lead us to *a priori* insights, even though we may be unsure how to express and communicate them. When we realize that we find reconciliation with ourselves in the illness, so that life becomes richer and more joyful, then that is an *a priori* insight. It tells us something fundamentally important about life—something that can be recognized by others. If, however, we emphasize an empirical theory about the five stages of the dying process, with reconciliation as the final stage, then knowledge remains problematic and hypothetical. When eager helpers want to ‘help’ the patient to get from one stage to the next, it can become pretty bad.

The care of mental health

The problems on the way of life can certainly become big, serious, distressing, and frightening. I think I have shown so far that philosophers can reflect on these problems and thereby take on a task. But what if the problems of life belong to the field of psychiatry? Should the philosopher then not better reject the task and pass it on to a psychiatrist? I do not think that he should do that. In some circumstances it might be appropriate to try to arrange in health care and social services the necessary support and help for the patient, which dialogues in the Philosophical Practice cannot provide. The philosopher might have to tell his guest that they should stop their dialogues for the time being. However, under no circumstances should he stop them by giving his guest the feeling that normal dialogues with him or her would not be possible because of his or her illness.

People can become psychotic if they have to make experiences that are so threatening that the mental pain can not be endured anymore. The pain can become so frightening and shocking that it cannot even be controlled anymore by circulating around it. The physical conditions to deal with this pain fail—so the person is forced to find shelter in mental processes which we all know from dreaming and often call “primary processes”. The person starts to dream while awake, so to speak. This can happen to us all when we get into a situation that we experience as a severe threat to our existence. What is crucial here is not so much the potential danger for life but rather the painful experience of losing any possibility of self-determination. Even with a high fever, especially when children are affected, it can happen that the normal control of impressions fails, and that something is seen or heard what other people in the same situation do not perceive. When one of my sons was little, he called me one evening and told me that a wasp (which in my opinion could not be around) had circled around him and had finally flown away through the ceiling. I touched his forehead, which was red hot, and the temperature measured was above 105 degrees Fahrenheit, that is 40 degrees Celsius. Such feverish fantasies have usually passed by after a while, just as dreams are gone after waking up. The surreal dreams while being awake, however, as far as they are not caused by fever or drugs, do usually not pass by that quickly and easily and frequently have fatal effects.

One woman told me that she first became psychotic at an airport. On the return trip home after a seminar she had to change the plane, and she imagined that war had broken out and acted accordingly. But when the police arrived and they wanted to put her into psychiatry, she put together all her strength, as she told me, and behaved normally. She asserted that she was able to continue her journey, and she pointed

out that she had the company of a friend; and this friend also confirmed that the further journey would not be a problem. But after her arrival she was still put into psychiatry, for reasons I cannot explain here in greater detail. That was, as she said, an experience almost more shocking than the imagined war. She was put into a large, threatening building where people were behaving strangely and where the doors were locked behind her. Because of that, she found no reason to leave her dream world too quickly. The real disaster however, she said, happened after she had left her psychotic condition and was back home. She called this disaster a social avalanche. She lost her well-paid and socially highly respected job, friends stayed away from her, her husband divorced her, she felt that it was widely doubted whether she was sane. Her social position was thrown into an abyss, so to speak. The description of this problematic situation might sound dramatic, but in fact it is almost a trivialization, the woman explained to me, because the consequences of even the most terrible avalanche of the material world can at least be fixed and repaired so that a so-called normal life is possible afterwards. The avalanche she speaks of, however, destroys a world. With this statement I think she points out something very important, something really crucial. I want to say that the social avalanche she speaks of destroys the life-world in which she could have her place. I will illustrate how this happens with a brief description borrowed from a psychiatrist's lecture. With this presentation, he opens an art exhibition and refers to a painting called "border walkers". In psychiatry, we know "borderline" patients, he says, and he understands these "borderline" patients as a special form of border walkers: They live on the border between what we can understand and what we can not understand anymore. I think by that everything important is said. Without realizing it himself, this psychiatrist with his short remark had named the fatal idea which makes psychiatry a devastating avalanche: that we can not understand anymore what is going on in the world of the mentally ill.

On this side of the "borderline", we find healthy normality. Here we can assume that we can approach the other's expression from our own experience. What we express, communicate, or do can be understood on the basis of the life we experience. If in our own lives we try to express what we feel, we constantly make the experience that the expression fits more or less, applies more or less, satisfies more or less. We take a look at the expression that we have given our feelings and e.g. think: No, not entirely true. Or: That's the thing pretty much. Similarly, we can approach the expressions of the other. We e.g. tell him: I do not quite understand what you're saying, you need to explain that to me in greater detail. Or: Oh, yes, that makes sense. Or: Well, I think I understand what you're saying, but I do not quite know what to make of it. We assume that the statements of others express feelings we can understand. We certainly do not know exactly what the other feels, but we are touched and affected by his expression. We trust our feelings to understand those of others. Thus, we share the same life-world.

But if somebody is seen as being beyond the "borderline" of psychiatry, the disaster happens. He is banished from the common life-world, so to speak. He is suffering the fate of becoming incomprehensible, insane. We think that we can not understand anymore what he expresses. His expression, we imagine, is about disease. And the essence of diseases is, as I have already emphasized, nothing we can experience. We can realize it only by its symptoms and effects. We might understand and experience these effects, but our understanding and our experiences, as important as they might seem to us subjectively, tell us nothing about the disease itself. Therefore there is no point in approaching the problem of the disease from one's own life experience. Then, we have to take "stronger" methods, we have to be scientific, we have to gather data systematically and create new theories and models that help us explain and hopefully handle the effects of the disease.

It is certainly difficult to understand why some people become psychotic and others do not. That living conditions are difficult, threatening or humiliating can obviously not explain everything, because some people experience the worst but still do not become psychotic. Others experience something that does not

seem so bad, and yet they become psychotic. It looks as if some people are more vulnerable than others. They are so much affected and shocked by life experiences most people could cope with that they can not digest and control their impressions anymore, and so they are swept away by imaginations that are carried by the sea of the unconscious.

Løgstrup makes clear how vulnerable we are as human beings when he describes human life as daring to step forward to be met by whom we encounter. We know this vulnerability from our own lives and can understand it quite well when we see other people being rejected, persecuted, humiliated. In psychiatry, however, it is stated that vulnerability is the factor causing psychoses and mental illness. This causal relation is then no longer comprehensible. It becomes a scientific hypothesis which must be verified empirically. Then vulnerability is no longer an experienced vulnerability but rather a defined one, observed according to certain criteria and supposedly leading to mental illness. This approach corresponds to the logic of empirical research; so we might think that nothing is wrong with it. Nevertheless, I have two objections to the psychiatric concept of vulnerability: First, it contributes to a mystification of the experienced and felt vulnerability which we know from life. Questions arise making us insecure: If we are vulnerable, if we feel hurt, is that something pathological, possibly dangerous? Can we no longer dare to competently speak of our own wounds? The psychiatric concept of vulnerability takes away our very natural ability to speak of vulnerability in everyday life. And secondly, the concept contributes to a fixed idea of mental disease. This is no objection to the common experience that we as a people can become mentally (or emotionally) ill, but rather an objection to the idea of mental disease. If we are attacked by such a disease, we can not understand anymore what we experience. Thus, we can not trust even our own feelings. If others do not understand it at all, we can not tell anyone what it means, not even ourselves. This is disastrous, because we then lose our life-world.

There has been much discussion about what “life-world” actually means. I think it is the common world we know “from within”. Opposed to that, the world of diseases is one we know from the “outside,” guided by theoretical concepts and models we learned. The world we know from the inside is the world we can describe from our experiences and feelings. This is the world to which we are physically connected, in which we are bodily present. We can speak of this world from our experience. It is a common world, because we share our stories and descriptions of it with each other and can assess and judge it on the basis of having a feeling for it. The theoretically acquired world, however, is not the common life-world because we are not present in it bodily. We know it “only with the head,” as we sometimes say. But worlds constructed with the help of concepts also presuppose and rest upon the life-world, because our ideas become too abstract and therefore incomprehensible if they do not relate in any way to the life-world. I can not deal more thoroughly here with the difficult concept of the life-world which Husserl has presupposed in his phenomenology. On the one hand, the life-world is one we all share, there are no life-worlds of individual human beings, as it is sometimes stated,—only individual life in the common life-world, of course. On the other hand, the life-world is not of such nature that we can find it somewhere. Something like a pure life-world does not exist—in addition to limited worlds, in addition to social and cultural worlds, in addition to the world of the empirical sciences, in addition to constructed worlds, in addition to all sorts of “head worlds.” Also, the life-world is not the “ideal world.” As I said, I can not explain here in detail the complexity of the life-world concept, but I wish to emphasize one key point: that the life-world is the world we all share and know “from within”. And that means not only that we are connected with it by experience and feeling, but also that we can understand what we mean when we describe and talk about it. Based on such understanding we can discuss all kinds of life-world events and communicate them. If we no longer believe that we can understand what someone tells us, we take away from him the common life-world and put him into a special world. That’s what happens in psychiatry very easily.

Some years ago a man came into my practice who told me that he did not like to leave his house anymore. He had realized that he spread a weariness infecting others around him. For example, he did not like to go to the supermarket, because customers coming too close to him began to yawn and to show more and more that they feel tired and powerless. At that time I did something that I would not do anymore today. I told him that it was not quite conceivable that he could spread weariness through his mere presence. I remember very well how hard he insisted that he really exercised this malign influence. He could remember exactly how other people reacted to him. So he defended the soundness of his experience. We can say that he had to fight the possibility that others could not understand what he had experienced. Today I think I should not have questioned his place in the common life-world. It was completely unnecessary, also because it is something quite familiar that we have an influence on others by our mere presence. I had every reason to ask what exactly he had experienced. I had every reason to wonder about his experiences—together with him. I am sure that if he felt being taken seriously, it would also be possible to talk about the normal or abnormal, the likely or unlikely aspects of his experiences. Then it would be quite possible to tell him what I myself think. For the fact that we would possibly have different views would not threaten his position in the common life-world.

I would now expect the following reaction from mental health workers: It is easy to say that we should wonder about what the patients say together with them. But should we really agree with them? Should we not say in many cases, for example: I believe you that you experience it like that, but I myself do not!? My answer to this question is that we should neither agree nor disagree with the patient but rather recognize his experience. If we tell him: I believe you that you experience it like that—then we do not really recognize his experience, at best only seemingly. Mostly we imply that we can not understand what he experiences, and not because of our own inadequacy. We might just as well say: I think you're crazy. And this is the message the patient actually receives.

Psychotherapists and mental health workers, and by the way educators as well, are in a paradoxical situation. They are committed to ensuring that the patient, client or student experiences a change for the better. However, this improvement must come from the patient, client or student himself. The therapists or teachers thus want to achieve an improvement which they can not produce themselves in a controlled way. In psychiatry, this paradox is carried to extremes. Treatment shall improve the patient's health. This health, however, is identical with the normality of the patient. To observe whether the patient's health is improving becomes the same as to determine whether he (or she) is responding and acting more normally. But how could it be that somebody suddenly becomes more normal after his normality has been denied? For a therapist, such a change might be imaginable. For the patient, however, such a change is initially completely impossible, because normality has been denied to him from the outside and can therefore be given back to him only from the outside. This leads to the situation that patients who are capable of doing so strive to fulfill the expectations—because they want to be good patients, because they want to escape from psychiatry or due to other reasons—, whereas patients who are not capable of doing so remain incurably ill. And if the patients who had shown improvement feel worse again and they again end up in a mental hospital, you know that they had not really been healed. The disease becomes an entity that the patient not only has, but that he rather is identical with. Psychiatric patients are schizophrenic, they are bipolar, whereas patients who had a heart attack are not reduced to this heart attack. Thus, the mental disease becomes a disease of this individual's nature. That triggers a certain fear which affects not only the patient but also the therapist. Becoming mentally ill is a fatal event, a banishment from the life-world, something horrible.

The (already mentioned) Norwegian philosopher Hans Skjervheim has shown how educators can get away from the paradox of education. In his essay "A fundamental problem of educational philosophy," he

has described how educators, when they realize that they can not methodically shape a student, easily pass on to the opposite view and think they need to let him grow freely. However, letting him grow freely is just as impossible as shaping him systematically. From this paradox, there is only one way out: understanding the educational activity as a dialogue between educator and the one to be educated, a dialogue in which both are shaping and shaped at the same time. Referring to Plato's dialogue Phaidros, Skjervheim (2002, p 117) calls this process "psychagogy, guidance of the soul through words." I think that the only way out of the paradox of psychiatric treatment has to be dialogical as well. We must assume that on the basis of a common understanding both sides, the therapist as well as the patient, can communicate the experiences of mental illness and encounter each other. This will demand a lot from both of them, maybe more than they are really able to cope with. But the enormous fear of being banned from the life-world is taken away from them. However, a requirement for that is that the idea of a mental disease is abandoned or loosened. Diagnoses are either to be avoided, or they must be seen as preliminary descriptions, as snapshots. Someone is then for example tired, now drowsy, now psychotic, paranoid, manic, and so on. A psychosis is not a dangerous disease threatening one's personality but rather a dream while being awake that can have disastrous consequences if it is not met by adequate means; but for others it is usually not dangerous. If one is not afraid of psychoses, it is not too difficult to encounter somebody psychotic in an appropriate way. The woman who had become psychotic at the airport told me that if she became psychotic again, she would just want to have someone around who was not afraid and who was ready to be together with her until the psychotic attack was over. She also told me that psychoses leave behind memories that do not easily and quickly fade away, like the dreams of the night after waking up, but that rather stay in mind and have to be digested. This digesting would be difficult, however, because as soon as she spoke of the psychotic contents, this would trigger the fear in others that her psychosis could break out again.

A psychiatrist once told me: "When I meet a psychotic patient, he either leaves the psychotic condition and comes toward me, or he moves away from me deeper into the psychotic state. And the scary thing is," she added, "I suspect it has to do with me." Similar experiences are made by mental health workers working "systemically." They might proceed according to the reflecting processes developed by Tom Andersen (see 1991, cf. also Anderson & Jensen, 2007), or they might follow the principles of the Open Dialogue presented by Jaakko Seikkula (see 1996, cf. also Seikkula & Olson, 2003). In these cases, health care workers make the experience that psychotic or mentally ill people find orientation in life again and are able to master their lives as well as possible. If their place in the common life-world is not taken away from them (anymore), they can often be saved from a (further) "career" in psychiatry. Philosophical Practitioners, who have no intention to treat their guests and therefore avoid the paradox of the helper, can actually play a role in these processes. As philosophers, they are open enough to allow the expression of the other to make an impression on them. The question is whether health care is open for such a practice.

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Correspondence: anders.lindseth@uin.no





PHILOSOPHICAL PRACTICE

Journal of the APPA

Volume 7 Number 3 November 2012

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Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America

Robert Whitaker

Cambridge, MA

Over the past 50 years, there has been an astonishing increase in severe mental illness in the United States. The percentage of Americans disabled by mental illness has increased fivefold since 1955, when Thorazine—remembered today as psychiatry's first “wonder” drug—was introduced into the market. The number of Americans disabled by mental illness has nearly doubled since 1987, when Prozac—the first in a second generation of wonder drugs for mental illness—was introduced. There are now nearly 6 million Americans disabled by mental illness, and this number increases by more than 400 people each day. A review of the scientific literature reveals that it is our drug-based paradigm of care that is fueling this epidemic. The drugs increase the likelihood that a person will become chronically ill, and induce new and more severe psychiatric symptoms in a significant percentage of patients.

Keywords: antipsychotics; antidepressants; mental illness; epidemic; schizophrenia

The modern era of psychiatry is typically said to date back to 1955, when chlorpromazine, marketed as Thorazine, was introduced into asylum medicine. In 1955, the number of patients in public mental hospitals reached a high-water mark of 558,922 and then began to gradually decline, and historians typically credit this emptying of the state hospitals to chlorpromazine. As Edward Shorter wrote in his 1997 book, *A History of Psychiatry*, “Chlorpromazine initiated a revolution in psychiatry, comparable to the introduction of penicillin in general medicine” (Shorter, 1997, p. 255). Haldol and other antipsychotic medications were soon brought to market, and then antidepressants and anti-anxiety drugs. Psychiatry now had drugs said to target specific illnesses, much like insulin for diabetes.

However, since 1955, when this modern era of psychopharmacology was born, there has been an astonishing rise in the incidence of severe mental illness in this country. Although the number of hospitalized mentally ill may have gone down, every other metric used to measure disabling mental illness in the United States has risen dramatically, so much so that E. Fuller Torrey, in his 2001 book *The Invisible Plague*, concluded that insanity had risen to the level of an “epidemic” (Torrey, 2001). Since this epidemic has unfolded in lockstep with the ever-increasing use of psychiatric drugs, an obvious question arises: Is our drug-based paradigm of care fueling this modern-day plague?

THE EPIDEMIC

The U.S. Department of Health and Human Services uses "patient care episodes" to estimate the number of people treated each year for mental illness. This metric tracks the number of people treated at psychiatric hospitals, residential facilities for the mentally ill, and ambulatory care facilities. In 1955, the government reported 1,675,352 patient care episodes, or 1,028 episodes per 100,000 population. In 2000, patient-care episodes totaled 10,741,243, or 3,806 per 100,000 population. That is nearly a fourfold per capita increase in 50 years (Table 1).

A second way to assess this epidemic is to look at the number of disabled mentally ill in the country. Up until the 1950s, the number of hospitalized mentally ill provided a rough estimate of this group. Today, the disabled mentally ill typically receive a disability payment either from the Social Security Disability Insurance (SSDI) program or the Supplemental Security Income (SSI) program, and many live in residential shelters or other subsidized living arrangements. Thus, the hospitalized patient of 50 years ago receives either SSDI or SSI today, and this line of evidence reveals that the number of disabled mentally ill has increased nearly sixfold since Thorazine was introduced.

In 1955, there were 559,000 people in public mental hospitals, or 3.38 people per 1,000 population. In 2003, there were 5.726 million people who received either an SSI or SSDI payment (or from both programs), and were either disabled by mental illness (SSDI statistics) or diagnosed as mentally ill (SSI statistics).¹ That is a disability rate of 19.69 people per 1,000 population, which is nearly six times what it was in 1955 (Table 2).

It is also noteworthy that the number of disabled mentally ill has increased dramatically since 1987, the year Prozac was introduced. Prozac was touted as the first of a second generation of psychiatric medications said to be so much better than the old. Prozac and the other SSRIs replaced the tricyclics, while the atypical antipsychotics (Risperidone, Zyprexa, etc.) replaced Thorazine and the other standard neuroleptics. The combined sales of antidepressants and antipsychotics jumped from around \$500 million in 1986 to nearly \$20 billion in 2004 (from September 2003 to August 2004), a 40-fold

TABLE 1. Patient-Care Episodes

Year	Total Episodes	Per 100,000 Population
1955	1,675,352	1,028
1965	2,636,525	1,376
1969	3,682,454	1,853
1971	4,190,913	2,026
1975	6,857,597	3,182
1983	7,194,038	3,084
1986	7,885,618	3,295
1990	8,620,628	3,491
1992	8,824,701	3,580
1994	9,584,216	3,680
1998	10,549,951	3,903
2000	10,741,243	3,806

Data Source: U.S. Department of Health and Human Services, SAMHSA. *Mental Health, United States*, 2002. Per 100,000 numbers calculated according to U.S. Census.

TABLE 2. The Disabled Mentally Ill in the United States

Year	Rate of Disabled Mentally Ill per 1,000 Population
1850	.2
1903	1.86
1955	3.38
1987	13.75
2003	19.69

Source: The disability rates for 1850 through 1955 are based on the number of hospitalized mentally ill, as cited by E. Fuller Torrey in *The Invisible Plague* (2001). The disability rates for 1987 and 2003 are based on the number of mentally ill receiving SSI or SSDI payments, as was reported in 2004 by the Social Security Administration.

increase.² During this period, the number of disabled mentally ill in the United States, as calculated by the SSI and SSDI figures, increased from 3.331 million people to 5.726 million.³ That is an increase of 149,739 people per year, or 410 people newly disabled by mental illness *every day* (Table 3).

A BIOLOGICAL CAUSE FOR THE EPIDEMIC

The notion that psychiatric drugs work by balancing brain chemistry was first raised in the early 1960s. Once Thorazine and the standard neuroleptics were shown to block dopamine activity in the brain, researchers hypothesized that schizophrenia was caused by too much of this neurotransmitter. Thus, the neuroleptics—by blocking the dopamine receptors—helped normalize the brain's dopamine system. Since the tricyclics raised norepinephrine and serotonin levels in the brain, researchers reasoned that depression was caused by low levels of these brain chemicals. Merck, meanwhile, marketed its anti-anxiety drug Suavitil as a "mood normalizer." These normalizing claims suggested that the drugs were indeed curative of biological ailments.

However, this hypothesis—that the drugs balanced abnormal brain chemistry—never panned out. Although the public may still be told that the drugs normalize brain chemistry, the truth is that researchers did not find that people with schizophrenia had overactive dopamine systems (prior to being medicated), or that those diagnosed with depression suffered from abnormally low levels of serotonin or norepinephrine. As U.S. Surgeon General David Satcher acknowledged in his 1999 report on mental health, the causes of mental disorders "remain unknown" (Satcher, 1999, p. 102).

Yet, scientists have come to understand how the drugs affect the human brain, at least in terms of their immediate mechanisms of action. In 1996, the director of the National Institute of Mental Health (NIMH), neuroscientist Steven Hyman, set forth a paradigm for understanding how all psychiatric drugs work. Antipsychotics, antidepressants, and anti-anxiety drugs, he wrote, "create perturbations in neurotransmitter functions" (Hyman & Nestler, 1996, p. 153). In response, the brain goes through a series of

TABLE 3. Disability in the Prozac Era

Year	SSDI Recipients Disabled by Mental Illness	SSI Recipients With Diagnosis of Mental Illness	Total Number of SSI and SSDI Payments to Disabled Mentally Ill	Number of SSDI Recipients Who Also Received an SSI Payment	Total Disabled Mentally Ill
1987	800,139	2,630,999	3,431,138	100,017	3,331,121
2003	1,812,021	4,141,418	5,953,439	226,502	5,726,937
Increase from 1987-2003	1,011,882	1,510,419	2,522,301		2,395,816

Data Source: Annual Statistical Report on the Social Security Disability Insurance Program, 2003; and SSI Annual Statistical Report, 2003.

compensatory adaptations. For instance, Prozac and other SSRI antidepressants block the reuptake of serotonin. In order to cope with this hindrance of normal function, the brain tones down its whole serotonergic system. Neurons both release less serotonin and down-regulate (or decrease) their number of serotonin receptors. The density of serotonin receptors in the brain may decrease by 50% or more. As part of this adaptation process, Hyman noted, there are also changes in intracellular signaling pathways and gene expression. After a few weeks, Hyman concluded, the patient's brain is functioning in a manner that is "qualitatively as well as quantitatively different from the normal state" (Hyman & Nestler, 1996, p. 161).

In short, psychiatric drugs induce a *pathology*. Princeton neuroscientist Barry Jacobs has explicitly made this point about SSRIs. These drugs, he said,

alter the level of synaptic transmission beyond the physiologic range achieved under (normal) environmental/biological conditions. Thus, any behavioral or physiologic change produced under these conditions might more appropriately be considered pathologic, rather than reflective of the normal biological role of serotonin. (Jacobs, 1991, p. 22)

Once psychiatric drugs are viewed in this way, it is easy to understand why their widespread use would precipitate an epidemic of mental illness. As E. Fuller Torrey wrote in *The Invisible Plague*, conditions that "disrupt brain chemistry may cause delusions, hallucinations, disordered thinking, and mood swings—the symptoms of insanity" (Torrey, 2001, p. 315). He noted that infectious agents, tumors, metabolic and toxic disorders, and various diseases could all affect the brain in this manner. What Torrey failed to mention is that psychiatric medications also "disrupt brain chemistry." As a result, their long-term use is bound to be problematic, and that is precisely what the research literature reveals: Their use increases the likelihood that a person will become chronically ill, and they cause a significant percentage of patients to become ill in new and more severe ways.

TURNING PATIENTS CHRONICALLY ILL

Neuroleptics

The study that is still cited today as proving the efficacy of neuroleptics for curbing acute episodes of schizophrenia was a nine-hospital trial of 344 patients conducted by the NIMH in the early 1960s. At the end of 6 weeks, 75% of the drug-treated patients were "much improved" or "very much improved" compared to 23% of the placebo patients. (National Institute of Mental Health Psychopharmacology Services Center Collaborative Study Group, 1964).

However, 3 years later, the NIMH reported on 1-year outcomes for the patients. Much to their surprise, they found that "patients who received placebo treatment were less likely to be rehospitalized than those who received any of the three active phenothiazines" (Schooler, Goldberg, Boothe, & Cole, 1967, p. 991). This result raised an unsettling possibility: While the drugs were effective over the short term, perhaps they made people more biologically vulnerable to psychosis over the long run, and thus the higher rehospitalization rates at the end of 1 year.

In the wake of that disturbing report, the NIMH conducted two medication-withdrawal studies. In each one, relapse rates rose in correlation with neuroleptic dosage before withdrawal. In the two trials, only 7% of patients who were on placebo relapsed

during the following 6 months. Twenty-three percent of the patients on less than 300 mg of chlorpromazine daily relapsed following drug withdrawal; this rate climbed to 54% for those receiving 300-500 mg and to 65% for patients taking more than 500 mg. The researchers concluded: "Relapse was found to be significantly related to the dose of the tranquilizing medication the patient was receiving before he was put on placebo—the higher the dose, the greater the probability of relapse" (Prien, Levine, & Switalski, 1971, p. 22).

Once again, the results suggested that neuroleptics increased the patients' biological vulnerability to psychosis. Other reports soon deepened this suspicion. Even when patients reliably took their medications, relapse was common, and researchers reported in 1976 that it appeared that relapse during drug administration was greater in severity than when no drugs were given (Gardos & Cole, 1977). A retrospective study by Bockoven also indicated that the drugs were making patients chronically ill. He reported that 45% of patients treated at Boston Psychopathic Hospital in 1947 with a progressive model of care did not relapse in the 5 years following discharge, and that 76% were successfully living in the community at the end of that follow-up period. In contrast, only 31% of patients treated in 1967 with neuroleptics at a community health center remained relapse-free over the next 5 years, and as a group they were much more "socially dependent"—on welfare and needing other forms of support—than those in the 1947 cohort (Bockoven & Solomon, 1975).

With debate over the merits of neuroleptics rising, the NIMH revisited the question of whether newly admitted schizophrenia patients could be successfully treated without drugs. There were three NIMH-funded studies conducted during the 1970s that examined this possibility, and in each instance, the newly admitted patients treated without drugs did better than those treated in a conventional manner. In 1977, Carpenter reported that only 35% of the non-medicated patients in his study relapsed within a year after discharge, compared to 45% of those treated with neuroleptics (Carpenter, McGlashan, & Strauss, 1977). A year later, Rappaport reported that in a trial of 80 young male schizophrenics admitted to a state hospital, only 27% of patients treated without neuroleptics relapsed in the 3 years following discharge, compared to 62% of the medicated group (Rappaport, Hopkins, Hall, Belleza, & Silverman, 1978). The final study came from Mosher, head of schizophrenia research at the NIMH. In 1979, he reported that patients who were treated without neuroleptics in an experimental home staffed by nonprofessionals had lower relapse rates over a 2-year period than a control group treated with drugs in a hospital. As in the other studies, Mosher reported that the patients treated without drugs were the better functioning group as well (Bola & Mosher, 2003; Mathews, Roper, Mosher, & Mann, 2003).

The three studies all pointed to the same conclusion: Exposure to neuroleptics increased the long-term incidence of relapse. Carpenter's group defined the conundrum:

There is no question that, once patients are placed on medication, they are less vulnerable to relapse if maintained on neuroleptics. But what if these patients had never been treated with drugs to begin with? We raise the possibility that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness. (Carpenter & McGlashan, 1977, p. 19)

In the late 1970s, two physicians at McGill University in Montreal offered a biological explanation for why this was so (one that fits with the paradigm later outlined by Hyman). The brain responds to neuroleptics—which block 70% to 90% of all D_2 dopamine receptors in the brain—as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D_2 receptors by 30% or more. The

brain is now "supersensitive" to dopamine, and this neurotransmitter is thought to be a mediator of psychosis. The person has become more biologically vulnerable to psychosis and is at particularly high risk of severe relapse should he or she abruptly quit taking the drugs (Chouinard, Jones, & Annable, 1978; Chouinard & Jones, 1980). The two Canadian researchers concluded:

Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. (Chouinard, Jones, & Annable, 1978, p. 1410)

Together, the various studies painted a compelling picture of how neuroleptics shifted outcomes away from recovery. Bockoven's retrospective and the other experiments all suggested that with minimal or no exposure to neuroleptics, at least 40% of people who suffered a psychotic break and were diagnosed with schizophrenia would not relapse after leaving the hospital, and perhaps as many as 65% would function fairly well over the long term. However, once first-episode patients were treated with neuroleptics, a different fate awaited them. Their brains would undergo drug-induced changes that would increase their biological vulnerability to psychosis, and this would increase the likelihood that they would become chronically ill (and thus permanently disabled).

That understanding of neuroleptics had been fleshed out by the early 1980s, and since then, other studies have provided additional confirming evidence. Most notably, the World Health Organization twice compared schizophrenia outcomes in the rich countries of the world with outcomes in poor countries, and each time the patients in the poor countries—where drug usage was much less—were doing dramatically better at 2-year and 5-year follow-ups. In India, Nigeria and Colombia, where only 16% of patients were maintained continuously on neuroleptics, roughly two-thirds were doing fairly well at the end of the follow-up period and only one third had become chronically ill. In the US and other rich countries, where 61% of the patients were kept on antipsychotic drugs, the ratio of good-to-bad outcomes was almost precisely the reverse. Only about one third had good outcomes, and the remaining two thirds became chronically ill (Jablensky et al., 1992; Leff, Sartorius, Jablensky, Korten, & Ernberg, 1992).

More recently, MRI studies have shown the same link between drug usage and chronic illness. In the mid 1990s, several research teams reported that the drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia (Chakos et al., 1994; Gur et al., 1998; Madsen, Keiding, Karle, Esbjerg, & Hemmingsen, 1998). These were disquieting findings, as they clearly showed that the drugs were causing structural changes in the brain. Then, in 1998, researchers at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia was "associated with greater severity of both negative and positive symptoms" (Gur, Maany et al., 1998, p. 1711). In other words, they found that over the long term the drugs cause changes in the brain associated with a *worsening* of the very symptoms the drugs are supposed to alleviate. The MRI research, in fact, had painted a very convincing picture of a disease process: An outside agent causes an observable change in the size of brain structures, and as this occurs, the patient deteriorates.

Antidepressants

The story of antidepressants is a bit subtler, and yet it leads to the same conclusion that these drugs increase chronic illness over time. Even their short-term efficacy, in terms of a benefit greater than placebo, is of a questionable sort.

In the early 1960s, there were two types of antidepressants, monoamine oxidase inhibitors (MAOIs) and tricyclics. However, MAOIs soon fell out of favor because of dangerous side effects and a 1965 finding by the Medical Research Council in the United Kingdom that they were no more effective than placebo (Medical Research Council, 1965). Four years later, the NIMH concluded that there was also reason to doubt the merits of tricyclics. After reviewing the medical literature, NIMH investigators determined that in "well-designed studies, the differences between the effectiveness of antidepressant drugs and placebo are not impressive" (Smith, 1969, p. 19). About 61% of the drug-treated patients improved, versus 46% of the placebo patients, producing a net drug benefit of only 15% (Smith, 1969).

This finding led some investigators to wonder whether the placebo response was the mechanism that was helping people feel better. What the drugs did, several speculated, was amplify the placebo response, and they did so because they produced physical side effects that helped convince patients that they were getting a "magic pill" for depression. To test this hypothesis, investigators conducted at least eight studies in which they compared a tricyclic to an "active" placebo, rather than an inert one. (An active placebo is a chemical that produces an unpleasant side effect of some kind, like dry mouth.) In seven of the eight, there was no difference in outcomes, leading investigators at New York Medical College to conclude "there is practical value in viewing [psychotropics] as mere amplifiers or inhibitors of the placebo effects" (Dinnerstein, Lowenthal, & Blitz, 1966; Thompson, 1982).

With such confusion over the efficacy of tricyclics hanging in the air, the NIMH launched an ambitious long-term study of depression treatments in the early 1980s. Two hundred thirty-nine patients were randomized into four treatment groups—cognitive behavior therapy, interpersonal therapy, the tricyclic imipramine, and placebo. The results were startling. At the end of 16 weeks, "there were no significant differences among treatments, including placebo plus clinical management, for the less severely depressed and functionally impaired patients." Only the severely depressed patients fared better on a tricyclic than on placebo. However, at the end of 18 months, even this minimal benefit disappeared. Stay-well rates were best for the cognitive behavior group (30%) and poorest for the imipramine group (19%) (Elkin, 1990). Moreover, two pharmacology researchers at the State University of New York, Seymour Fisher and Roger Greenberg, concluded that if study dropouts were included in the analysis, then the "results look even worse" (Greenberg & Fisher, 1997, p. 147). Patients treated with an antidepressant were the most likely group to seek treatment following termination of the initial treatment period, they had the highest incidence of relapse, and they "exhibited the fewest weeks of reduced or minimal symptoms during the follow-up period" (Greenberg & Fisher, 1997, p. 147).

Once again, the results led to an unnerving conclusion. Antidepressants were making people chronically ill, just like the antipsychotics were. Other studies deepened this suspicion. In 1985, a U.K. group reported that in a 2-year study comparing drug therapy to cognitive therapy, relapse "was significantly higher in the pharmacotherapy group" (Blackburn, Eunson, & Bishop, 1986, p. 67). In 1994, Italian researcher Giovanni Fava reviewed the outcomes literature and concluded that "long-term use of antidepressants may increase the (patient's) biochemical vulnerability to depression," and thus "worsen the course of affective disorders" (Fava, 1994, p. 127). Fava revisited the issue in 2003. An analysis of 27 studies, he wrote, showed that "whether one treats a depressed patient for 3 months or 3 years, it does not matter when one stops the drugs.

A statistical trend suggested that the longer the drug treatment, the higher the likelihood of relapse" (Fava, 2003, p. 124).

Benzodiazepines

This same basic paradox—that a psychiatric drug may curb symptoms over the short term but worsen the long-term course of the disorder—has been found to hold true for benzodiazepines, at least when used to treat panic attacks. In 1988, researchers who led the large Cross-National Collaborative Panic Study, which involved 1,700 patients in 14 countries, reported that at the end of 4 weeks, 82% of the patients treated with Xanax (alprazolam) were "moderately improved" or "better," versus 42% of the placebo patients. However, by the end of 8 weeks, there was no difference between the groups, at least among those who remained in the study (Ballenger et al., 1988). Any benefit with Xanax seemed to last for only a short period. As a followup to that study, researchers in Canada and the UK studied benzodiazepine-treated patients over a period of 6 months. They reported that the Xanax patients got better during the first four weeks of treatment, that they did not improve any more in weeks 4 to 8, and that their symptoms began to worsen after that. As patients were weaned from the drugs, a high percentage relapsed, and by the end of 23 weeks, they were worse off than patients treated without drugs on five different outcomes measures (Marks et al., 1993). More bad news of this sort was reported by Pecknold in 1988. He found that as patients were tapered off Xanax they suffered nearly four times as many panic attacks as the nondrug patients, and that 25% of the Xanax patients suffered from rebound anxiety more severe than when they began the study. The Xanax patients were also significantly worse off than nondrug patients on a global assessment scale by the end of the study (Pecknold, Swinson, Kuch, & Lewis, 1988).

Then and Now

Research by David Healy, a prominent U.K. psychiatrist who has written several books on the history of psychopharmacology, shows how this problem of drug-induced chronicity plays out in society as a whole. Healy determined that outcomes for psychiatric patients in North Wales were much better a century ago than they are today, even though patients back then, at their moment of initial treatment, were much sicker. He concluded that today's drug-treated patients spend much more time in hospital beds and are "far more likely to die from their mental illness than they were in 1896." "Modern treatments," he said, "have set up a revolving door" and appear to be a "leading cause of injury and death" (Healy et al., 2001).

MANUFACTURING MENTAL ILLNESS

It is well known that all of the major classes of psychiatric drugs—antipsychotics, antidepressants, benzodiazepines, and stimulants for ADHD—can trigger new and more severe psychiatric symptoms in a significant percentage of patients. This is the second factor causing a rapid rise in the number of disabled mentally ill in the United States. Moreover, it is easy to see this epidemic-creating factor at work with Prozac and the other SSRIs.

Although serotonin has been publicly touted as the brain's mood molecule, in truth it is a very common chemical in the body, found in the walls of the blood vessels, the gut, blood platelets, and the brain. The serotonin system is also one that could be said to be primitive in kind. Serotonergic neurons are found in the nervous systems of all vertebrates and most invertebrates, and in humans their cell bodies are localized along the midline of the brain stem. From there, their axons spread up into the brain and down into the spinal cord. The first purpose of this neuronal network is thought to be control of respiratory, cardiac, and repetitive motor activity, as opposed to higher cognitive functions.

As one would expect, perturbing this system—and to a degree that could be considered pathologic, as Jacobs said—causes a wide range of problems. In Prozac's first 2 years on the market, the FDA's Medwatch program received more adverse-event reports about this new "wonder drug" than it had received for the leading tricyclic in the previous 20 years. Prozac quickly took up the top position as America's most complained-about drug, and by 1997, 39,000 adverse-event reports about it had been sent to Medwatch. These reports are thought to represent only 1% of the actual number of such events, suggesting that nearly 4 million people in the US had suffered such problems, which included mania, psychotic depression, nervousness, anxiety, agitation, hostility, hallucinations, memory loss, tremors, impotence, convulsions, insomnia, and nausea. The other SSRIs brought to market caused a similar range of problems, and by 1994, four SSRIs were among the top 20 most complained-about drugs on the FDA's Medwatch list (Moore, 1997).

In terms of helping fuel a rapid rise in the number of disabled mentally ill, the propensity of Prozac and other SSRIs to trigger mania or psychosis is undoubtedly the biggest problem with these drugs. In clinical trials, slightly more than 1% of the Prozac patients developed mania, which was three times higher than the rate for patients given a tricyclic (Breggin, 2003). Other studies have found much higher rates of SSRI-induced mania. In 1996, Howland reported that 6% of 184 depressed patients treated with an SSRI suffered manic episodes that were "generally quite severe." A year later, Ebert reported that 8.5% of patients had a severe psychological reaction to Luvox (fluvoxamine) (Breggin). Robert Bourguignon, after surveying doctors in Belgium, estimated that Prozac induced psychotic episodes in 5% to 7% of patients (Bourguignon, 1997). All of this led the American Psychiatric Association to warn that manic or hypomanic episodes are "estimated to occur in 5% to 20% of patients treated with antidepressants" (Breggin).

As Fava has noted, "Antidepressant-induced mania is not simply a temporary and reversible phenomenon, but a complex biochemical mechanism of illness deterioration" (Fava, 2003, p. 126). The best available evidence suggests that this is now happening to well more than 500,000 Americans a year. In 2001, Preda and other Yale researchers reported that 8.1% of all admissions to a psychiatric hospital they studied were due to SSRI-induced mania or psychosis (Preda, MacLean, Mazure, & Bowers, 2001). The federal government reported that there were 10.741 million "patient care episodes" in 2000; if 8% were SSRI-induced manic or psychotic episodes, that would mean that 860,000 people suffered this type of adverse reaction in 2000.

Thus, the SSRI path to a disabling mental illness can be easily seen. A depressed patient treated with an antidepressant suffers a manic or psychotic episode, at which time his or her diagnosis is changed to bipolar disorder. At that point, the person is prescribed an antipsychotic to go along with the antidepressant, and once on a drug cocktail, the person is well along on the road to permanent disability. Since Prozac was

introduced in 1987, the number of disabled mentally ill in the US has risen by 2.4 million people, and given the risk of mania and psychosis with the SSRIs, that increase was to be expected.

CONCLUSION

A century ago, fewer than two people per 1,000 were considered to be "disabled" by mental illness and in need of hospitalization. By 1955, that number had jumped to 3.38 people per 1,000, and during the past 50 years, a period when psychiatric drugs have been the cornerstone of care, the disability rate has climbed steadily, and has now reached around 20 people per 1,000. (Table 2). As with any epidemic, one would suspect that an outside agent of some type—a virus, a bacterial infection, or an environmental toxin—was causing this rise in illness. That is indeed the case here. There is an outside agent fueling this epidemic of mental illness, only it is to be found in the medicine cabinet. Psychiatric drugs perturb normal neurotransmitter function, and while that perturbation may curb symptoms over a short term, over the long run it increases the likelihood that a person will become chronically ill, or ill with new and more severe symptoms. A review of the scientific literature shows quite clearly that it is our drug-based paradigm of care that is fueling this modern-day plague.

NOTES

1. These data come from the 2003 annual Social Security reports for the SSI and SSDI programs. The figure of 5,726,937 disabled mentally ill is calculated as follows: There were 1,812,021 SSDI recipients who were disabled because of mental illness. There were 4,141,418 SSI recipients diagnosed as mentally ill. However, one out of every eight recipients of SSDI, or 226,502 people, also received an SSI payment. Thus, the number of disabled mentally ill is: $1,812,021 + 4,141,418 - 226,502 = 5,726,937$.

2. In 1985, U.S. sales of antidepressants totaled \$240 million, and U.S. sales of antipsychotics were \$263 million. From September 1, 2003 to August 30, 2004, U.S. sales of antidepressants were \$11.2 billion, and U.S. sales of antipsychotics were \$8.6 billion. The source for the 1985 figures is Zore, Larson, Lyons, and Beardsley (1991). The 2004 sales figures are from IMS Retail Drug Monitor: 12 months to August 2004.

3. The calculation for the number of disabled mentally ill in 1987 is as follows: There were 800,139 SSDI recipients who were disabled because of mental illness. There were 2,630,999 SSI recipients diagnosed as mentally ill. One out of every eight recipients of SSDI, or 100,017 people, also received an SSI payment. Thus, the number of disabled mentally ill is: $800,139 + 2,630,999 - 100,017 = 3,331,120$.

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Offprints. Requests for offprints should be directed to Robert Whitaker, 19 Rockingham Street, Cambridge, MA 02139. E-mail: robert.b.whitaker@verizon.net

Robert Whitaker, A handout of studies

Antipsychotics and Schizophrenia/Psychosis

I. The Evidence Base for Current Standard of Care

- a) In short-term trials, antipsychotics knock down psychotic symptoms better than placebo
- b) In drug withdrawal studies (most with abrupt-withdrawal design), the drug-withdrawn patients relapse at a higher rate than the drug-maintained patients.

However, as Emmanuel Stip noted in a 2002 editorial in *European Psychiatry*, the relapse literature does not provide evidence that antipsychotics are shifting long-term outcomes for the better.

He wrote: “After fifty years of neuroleptics, are we able to answer the following simple question: Are neuroleptics effective in treating schizophrenia?” There was, he concluded, “No compelling evidence on the matter, when ‘long-term’ is considered.”

II. The Evidence that Challenges Conventional Wisdom

There are five lines of evidence related to long-term outcomes that challenge the conventional wisdom:

1. Evidence that antipsychotics induce a dopamine supersensitivity, which makes the brain more biologically vulnerable to psychosis.
2. MRI studies, which provide evidence that antipsychotics shrink brain volumes, and that this shrinkage is associated with an increase in negative symptoms and functional impairment.
3. Cross-cultural studies, which show better outcomes in developing countries when patients were not regularly maintained on antipsychotics, but do not in studies where all patients are medicated.
4. Long-term studies. Specifically, Martin Harrow’s longitudinal study, which found that over the long-term, unmedicated patients had much better outcomes, and a recent randomized study by Lex Wunderink, which found that recovery rates, at the end of seven years, were much higher for the group that was either tapered from their medications, or reduced to a low dose.
5. The good five-year outcomes in Western Lapland (Finland), where antipsychotics are used in a selective, cautious manner.

III. Drug-induced dopamine supersensitivity: Why this worry arose, and how it was tested

1. First, in the 1960s and 1970s, there were five studies that assessed longer-term outcomes in schizophrenia patients, and each one produced a surprising result.

a) NIMH's Study of One-Year Outcomes

This NIMH study looked at one-year outcomes for 299 patients who had been treated either with neuroleptics or placebo upon their admission to a hospital. This was the first long-term study conducted by the NIMH, and the researchers found that patients who received placebo "were less likely to be rehospitalized than those who received any of the three active phenothiazines."

Schooler, N. "One Year After Discharge." *American Journal of Psychiatry* 123 (1967): 986-995.

b) Bockoven's retrospective study.

In this study, Boston psychiatrists Sanbourne Bockoven and Harry Solomon compared relapse rates in the pre-drug era to those in the drug era, and found that patients in the pre-drug era had done better. Forty-five percent of the patients treated at Boston Psychopathic Hospital in 1947 had not relapsed in the five years following discharge, and 76% were successfully living in the community at the end of that follow-up period. In contrast, only 31% of patients treated in 1967 with drugs at a Boston community health center remained relapse-free for the next five years, and as a group they were much more "socially dependent"--on welfare, etc.--than those in the 1947 cohort.

Bockoven concluded: "Rather unexpectedly, these data suggest that psychotropic drugs may not be indispensable . . . Their extended use in aftercare may prolong the social dependency of many discharged patients."

Bockoven, J. "Comparison of Two Five-Year Follow-up Studies." *American Journal of Psychiatry* 132 (1975): 796-801.

c) Maurice Rappaport's Three-Year Study

In this 1978 study, Maurice Rappaport and his colleagues at the University of California, San Francisco randomized 80 young male schizophrenics admitted to Agnews State Hospital to drug and non-drug groups. Only 27% of the drug-free patients relapsed in the three years following discharge, compared to 62% of the medicated group. Most notably, only two of 24 patients (8 percent) who weren't medicated in the hospital and continued to forgo such treatment after discharge subsequently relapsed. At the end of the study, this group of 24 drug-free patients was functioning at a dramatically higher level than drug-treated patients.

Rappaport wrote: "Our findings suggest that antipsychotic medication is not the treatment of choice, at least for certain patients, if one is interested in long-term clinical improvement. Many unmedicated-while-in-hospital patients showed greater long-term improvement, less pathology at follow-up, fewer rehospitalizations, and better overall functioning in the community than patients who were given chlorpromazine while in the hospital."

Rappaport, M. "Are There Schizophrenics for Whom Drugs May be Unnecessary or Contraindicated?" *International Pharmacopsychiatry* 13 (1978):100-111.

d) Loren Mosher's Soteria Project

During the 1970s, the head of schizophrenia studies at the NIMH, Loren Mosher, conducted an experiment that compared treatment in a homelike environment (called Soteria), where antipsychotics were minimally used, to conventional treatment in a hospital setting. At the end of two years, the Soteria patients had "lower psychopathology scores, fewer (hospital) readmissions, and better global adjustment" than those treated conventionally with antipsychotics. Only 31% of the patients treated without drugs in the Soteria House who remained off neuroleptics after leaving the program relapsed over the next two years.

Mosher and Bola wrote: "Contrary to popular views, minimal use of antipsychotic medications combined with specially designed psychosocial intervention for patients newly identified with schizophrenia spectrum disorder is not harmful but appears to be advantageous. We think that the balance of risks and benefits associated with the common practice of medicating nearly all early episodes of psychosis should be re-examined."

Mathews, S. "A Non-Neuroleptic Treatment for Schizophrenia." *Schizophrenia Bulletin* 5 (1979), 322-332.

Mosher, L. "Community Residential Treatment for Schizophrenia." *Hospital and Community Psychiatry* 29 (1978), 715-723

Mosher, L. "The Treatment of Acute Psychosis Without Neuroleptics." *International Journal of Social Psychiatry* 41 (1995), 157-173.

Bola, J. "Treatment of Acute Psychosis Without Neuroleptics." *The Journal of Nervous and Mental Disease* 191 (2003):219-229.

e) NIMH's In-House Study, led by William Carpenter

In this 1977 NIMH study, outcomes for 27 schizophrenia patients, treated in an experimental hospital program that provided them with psychosocial support but didn't use antipsychotics were compared to outcomes for 22 patients treated with the same psychosocial care but also with antipsychotics. Only 35% of the non-medicated patients relapsed within a year after discharge, compared to 45% of those treated with medication. The medicated patients also suffered more from depression, blunted emotions, and retarded movements.

Carpenter, W. "The Treatment of Acute Schizophrenia Without Drugs." *American Journal of Psychiatry* 134 (1977): 14-20.

2. In the late 1970s, the surprising outcomes from the studies cited above led researchers at the top of the NIMH (beyond Loren Mosher) to question the long-term use of antipsychotics, and to worry that antipsychotics were inducing a biological change that increased the patient's vulnerability to psychosis over the long run.

a) Jonathan Cole

In 1977, Jonathan Cole, the former head of the NIMH Psychopharmacology Service Center, concluded that given the myriad of problems caused by antipsychotics, “every chronic schizophrenic outpatient maintained on an antipsychotic medication should have the benefit of an adequate trial without drugs.” He titled his article, “Is the Cure Worse than the Disease?”

Cole, J. “Maintenance Antipsychotic Therapy.” *American Journal of Psychiatry* 132 (1977): 32-6.

b) William Carpenter

William Carpenter raised this profound question:

“There is no question that, once patients are placed on medication, they are less vulnerable to relapse if maintained on neuroleptics. But what if these patients had never been treated with drugs to begin with? . . . We raise the possibility that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the normal course of the illness.”

Carpenter, W. “The Treatment of Acute Schizophrenia Without Drugs.” *American Journal of Psychiatry* 134 (1977): 14-20.

3. With this question now having been raised, two researchers at McGill University, Guy Chouinard and Barry Jones, presented a biological explanation for why antipsychotics would make patients more biologically vulnerable to psychosis. They dubbed it “drug-induced” supersensitivity psychosis.”

a) They set forth their hypothesis:

In several articles, they noted that because the drugs dampen dopamine activity, the brain tries to compensate by becoming “supersensitive” to dopamine. In particular, the drugs trigger an increase in the density of dopamine receptors. This perturbation in dopamine function, over the long term, makes the patients more biologically prone to psychosis and to worse relapses upon drug withdrawal, they argued.

Chouinard and Jones concluded: “Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who has developed such a supersensitivity is determined by more than just the normal course of the illness.”

Muller, P. “Dopaminergic Supersensitivity After Neuroleptics.” *Psychopharmacology* 60 (1978):1-11.

Chouinard, G. “Neuroleptic-Induced Supersensitivity Psychosis” *American Journal of Psychiatry* 135 (1978):1409-1410.

Chouinard, G. “Neuroleptic-Induced Supersensitivity Psychosis:” *American Journal of Psychiatry*

137 (1980):16-20.

b) Chouinard and Jones then tested their hypothesis.

They reasoned that just as some patients treated long-term with antipsychotics develop tardive dyskinesia, which is a sign of dysfunction in the basal ganglia, some patients develop a tardive psychosis, as a result of drug-induced dysfunction in the limbic system. In 1982, Chouinard and Jones reported that 30% of 216 schizophrenia outpatients showed signs of tardive psychosis, which meant that their psychosis was becoming chronic. When this sets in, “the illness appears worse” than ever before, they wrote. “New schizophrenic symptoms of greater severity will appear.”

Chouinard, G. “Neuroleptic-induced supersensitivity psychosis, the “hump course,” and tardive dyskinesia.” *Journal of Clinical Psychopharmacology* 2 (1982):143-4.

Chouinard, C. “Severe cases of neuroleptic-induced supersensitivity psychosis,” *Schiz Res* 5 (1991):21-33.

4. Philip Seeman’s animal models of psychosis

After Chouinard and Jones presented their hypothesis and tested it, psychiatry, by and large, didn’t pursue further investigations. However, Philip Seeman at the University of Toronto subsequently developed animal models of psychosis, and he has now reported three important findings:

In his model of psychosis, the various means he uses to trigger psychosis—illicit drugs, gene knockouts, lesions to the hippocampus—all ultimately cause an increase in D2 receptors that have a “high affinity” for dopamine. He wrote: These results “imply that there may be many pathways to psychosis, including multiple gene mutations, drug abuse, or brain injury, all of which may converge via D2 HIGH to elicit psychotic symptoms.

However, Seeman also reported that both haloperidol and olanzapine cause this same change, i.e., they dramatically increase the density of D2 receptors with a “HIGH” affinity for dopamine.

Finally, he then conducted a study, in rats, to determine whether this drug-induced change led to “treatment failure” over time. Although the antipsychotics initially blocked the “psychotic” behavior in rats, over time—as this drug-induced D2 HIGH sensitivity developed—the drugs lost their efficacy.

“

Seeman wrote: “We show that during ongoing treatment with clinically relevant doses, haloperidol and olanzapine progressively lose their efficacy . . . the loss of efficacy is linked to an increase in D2 receptor number and sensitivity. These results are the first to demonstrate that ‘breakthrough’ supersensitivity during ongoing antipsychotic treatment undermines treatment efficacy.”

Seeman, P. “Dopamine supersensitivity correlates with D2 HIGH states, implying many paths to psychosis. *Proceedings of the Nat Acad of Science* 102 (2005): 3513-18.

Samaha, A. “Breakthrough dopamine supersensitivity during ongoing antipsychotic treatment leads to treatment failure over time.” *J Neuroscience* 27 (2007):2979-86.

IV. MRI Studies of Brain Volumes

1. Background data

In the 1990s, several researchers reported that standard antipsychotics shrunk the frontal lobes, and there was also a report by Rachel Gur that the drugs caused an enlargement of the basal ganglia, and that this enlargement was associated with a worsening of the negative and positive symptoms of schizophrenia.

2. Study in monkeys

In a study with macaque monkeys, researchers reported that, treatment with either haloperidol or olanzapine for 17 to 27 months led to a “8-11% reduction in mean fresh brain weights” compared to controls. The differences (in brain weights and brain volumes) “were observed across all major brain regions, but appeared most robust in the frontal and parietal regions.”

Dorph-Petersen. “The influence of chronic exposure to antipsychotic medications on brain size before and after tissue fixation.” *Neuropsychopharmacology* (2005) 30: 1649-1661.

3. Nancy Andreasen’s MRI Study

In 1989, Nancy Andreasen, who was editor in chief of the *American Journal of Psychiatry*, began a long-term study of more than 500 schizophrenia patients. Here is a summary of her findings:

In 2003, Andreasen reported that schizophrenia was a “progressive neurodevelopmental disorder” characterized by “progressive reduction in frontal white matter volume.” This decline in brain volumes was seen in MRI imaging tests.

In 2003 and 2005, she reported that this brain shrinkage was associated with a worsening of negative symptoms, increased functional impairment, and, after five years, cognitive decline.

In 2011, Andreasen reported that this shrinkage was drug-related. Use of the old neuroleptics, the atypical antipsychotics, and clozapine were all “associated with smaller brain tissue volumes,” with decreases in both white and grey matter. The severity of illness and substance abuse had “minimal or no effect” on brain volumes.

In 2008, she said: “What exactly do these drugs do? They block basal ganglia activity. The prefrontal cortex doesn’t get the input it needs and is being shut down by drugs. That reduces psychotic symptoms. It also causes the prefrontal cortex to slowly atrophy.”

Ho, B. “Progressive structural brain abnormalities and their relationship to clinical outcome.” *Arch Gen Psych* 60 (2003):585-94.

Andreasen, N. “Longitudinal changes in neurocognition during the first decade of schizophrenia illness.” *International Congress on Schizophrenia Research* (2005):348.

Ho, B. “Long-term antipsychotic treatment and brain volumes.” *Arch Gen Psychiatry* 68 (2011):128-37.

4. A meta-analysis of 43 MRI studies

In a 2012 review of 43 brain-imaging studies of first-episode psychosis, European researchers determined that a loss of gray matter volume was “significantly more severe in medicated patients.”

Source: J. Radua. “Multimodal meta-analysis of structural and functional changes in first episode psychosis and the effects of antipsychotic medications.” *Neuroscience and Biobehavioral Review*, in press as of 9/04/2012.

V. Cross-Cultural Studies

1. The World Health Organization studies.

The first World Health Organization study that compared schizophrenia outcomes in “developed” and “developing” countries was called The International Pilot Study of Schizophrenia. It began in 1968, and involved 1202 patients in nine countries. At both two-year and five-year follow-ups, the patients in the poor countries were doing much better. The researchers concluded that schizophrenia patients in the poor countries “had a considerably better course and outcome than (patients) in developed countries. This remained true whether clinical outcomes, social outcomes, or a combination of the two was considered.” Two-thirds of the patients in India and Nigeria were asymptomatic at the end of five years. The WHO investigators, however, were unable to identify a variable that explained this notable difference in outcomes. See pages 132, 142, 143.

Leff, J. “The International Pilot Study of Schizophrenia.” *Psychological Medicine* 22 (1992):131-145.

The second WHO study of this type was called the Determinants of Outcome of Severe Mental Disorders. It involved 1379 patients from 10 countries, and was designed as a follow-up study to the International Pilot Study of Schizophrenia. The patients in this study were first-episode patients, and 86% had been ill fewer than 12 months. This study confirmed the findings of the first: two-year outcomes were much better for the patients in the poor countries. In broad terms, 37 percent of the patients in the poor countries (India, Nigeria and Colombia) had a single psychotic episode and then fully recovered; another 26.7% of the patients in the poor countries had two or more psychotic episodes but still were in “complete remission” at the end of the two years. In other words, 63.7% of the patients in the poor countries were doing fairly well at the end of two years. In contrast, only 36.9% of the patients in the U.S. and six other developed countries were doing fairly well at the end of two years. The researchers concluded that “being in a developed country was a strong predictor of not attaining a complete remission.”

Although the WHO researchers didn't identify a variable that would explain this difference in outcomes, they did note that in the developing countries, only 15.9% of patients were continuously maintained on neuroleptics, compared to 61% of patients in the U.S. and other developed countries.

Jablensky, A. “Schizophrenia: Manifestations, Incidence and Course in Different Cultures.” *Psychological Medicine, supplement* 20 (1992):1-95.

2. The 15-year to 20-year followup of the patients in the WHO studies

The “outcome differential” held up for “general clinical state, symptomatology, disability, and social functioning.” In the developing countries, 53% of schizophrenia patients were “never psychotic” anymore, and 73% were employed.

Hopper, K. “Revisiting the developed versus developing country distinction in course and outcome in schizophrenia.” *Schizophrenia Bulletin* 26 (2000):835-46.

3. Eli Lilly’s Global Study of Schizophrenia Outcomes

This is an Eli Lilly funded study of 11,078 schizophrenia patients in 37 countries. All patients were treated with olanzapine or another antipsychotic. In this study, functional outcomes of patients in non-European countries were as poor as in European countries (or even worse), with only around 25% enjoying functional remission. (The superiority in functional outcomes found by the WHO in developing countries has disappeared in this study where all patients are medicated.)

Haro, “Cross-national clinical and functional remission rates.” *Brit J of Psychiatry* 2011, 199: 194-201.

VI. Long-term Studies

1. Martin Harrow’s 20-year study

In this prospective study, Martin Harrow followed 64 schizophrenia patients and 81 diagnosed with a milder psychotic disorder for 20 years. A close examination of his 15-year data reveals the following results:

- At the end of 15 years, 40% of the schizophrenia patients off medication were in recovery, versus 5% of those on medication.
- At the end of 15 years, only 16% of schizophrenia patients off medication had a “uniformly poor” outcome, compared to 49% of those on medication.
- At the 10-year and 15-year follow-ups, the on-medication patients were two to three times more likely to still be experience psychotic symptoms
- The bad-prognosis schizophrenia patients off medication did better than the bad-prognosis patients on medication
- The good-prognosis schizophrenia patients off medication did better than the good-prognosis patients on medication
- Among those with milder psychotic disorders, the off-medication group did better
- The schizophrenia patients off medication did better over the long-term than the milder-disorders group that stayed on antipsychotic medications.

Harrow also provided results at the end of 20 years. Those who stayed on antipsychotic medications, as a group, were more anxious, had worse cognitive function, suffered more relapse, and were much less likely to ever work.

In a 2013 paper, Harrow raised this question: “How unique among medical treatments is it that the apparent efficacy of antipsychotics could diminish over time or become ineffective or harmful? There are many examples for other medications of similar long-term effects, with this often occurring as the body readjusts, biologically, to the medications.”

Harrow M. “Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications.” *Journal of Nervous and Mental Disease* 195 (2007):406-14.

Harrow, M. “Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study.” *Psychological Medicine*, (2012):1-11.

Harrow, M. “Does long-term treatment of schizophrenia with antipsychotic medications facilitate recovery?” *Schizophrenia Bulletin*, published online March 19, 2013

2. Lex Wunderink’s randomized seven-year study

In this study by Dutch researcher Lex Wunderink, 128 first-episode psychotic patients, after initial stabilization on an antipsychotic, were randomized either to a drug-withdrawal/low-dose arm, or to standard drug treatment. At the end of seven years, those in the withdrawal/low-dose group had much better functional outcomes (40.4% recovery rate, versus 17.6% for the treatment-as-usual group.) There was no significant difference in relapse rates at end of seven years between the two groups.

The researchers concluded: “Antipsychotic postsynaptic blockade of the dopamine signaling system, particularly of the mesocortical and mesolimbic tracts, not only might prevent and redress psychotic derangements but also might compromise important mental functions, such as alertness, curiosity, drive, and activity levels, and aspects of executive functional capacity to some extent.”

L. Wunderink. “Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation of maintenance treatment strategy.” *JAMA Psychiatry*, published online, July 3, 2013.

VII. Outcomes in Western Lapland

In Western Lapland, a region in northern Finland, psychiatrists developed a treatment called open-dialogue therapy that involves treating first-episode psychotic patients with a selective medication protocol. Initial use of antipsychotics is delayed to see if the patient can get better without going on the medications. If antipsychotic medication is subsequently seen as needed, patients may still be kept on the medication for only a shorter period of time. Western Lapland has been using this medication protocol since 1992, and has reported five-year outcomes for several cohorts of patients.

In this particular study of first-episode nonaffective psychotic patients, at the end of five years, 82% of the patients did not have psychotic symptoms, 86% had returned to their studies or were working, and only 14% were on a disability allowance. Only 29% of the patients had ever been exposed to an antipsychotic drug during the five years, and only 17% were on antipsychotics at the end of the study.

Seikkula, J. "Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach." *Psychotherapy Research* 16 (2006):214-228.

VIII. Editorial Comments Calling for a Rethinking of Use of Antipsychotics

1. *British Journal of Psychiatry*, August 2012.

"It is time to reappraise the assumption that antipsychotics must always be the first line of treatment for people with psychosis. This is not a wild cry from the distant outback, but a considered opinion by influential researchers . . . [there is] an increasing body of evidence that the adverse effects of [antipsychotic] treatment are, to put it simply, not worth the candle."

Peter Tyrer, Editor

2. *JAMA Psychiatry*, July 3, 2013 (online edition.)

"In moving to a more personalized or stratified medicine, we first need to identify the very small number of patients who may be able to recover from first episode psychosis with intensive psychosocial interventions alone. For everyone else, we need to determine which medication, for how long, in what minimal dose, and what range of intensive psychosocial interventions will be needed to help them get well, stay well, and lead fulfilling and productive lives. These factors have rarely been the goal in the real world of clinical psychiatry—something we must finally address now that we are armed with stronger evidence to counter poor practice."

McGorry, P. "Antipsychotic medication during the critical period following remission from first-episode psychosis: less is more." *JAMA Psychiatry*, published online, July 3, 2013.

Original Investigation

Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy

Long-term Follow-up of a 2-Year Randomized Clinical Trial

Lex Wunderink, MD, PhD; Roeline M. Nieboer, MA; Durk Wiersma, PhD;
Sjoerd Sytema, PhD; Fokko J. Nienhuis, MA

← Editorial

IMPORTANCE Short-term outcome studies of antipsychotic dose-reduction/discontinuation strategies in patients with remitted first-episode psychosis (FEP) showed higher relapse rates but no other disadvantages compared with maintenance treatment; however, long-term effects on recovery have not been studied before.

OBJECTIVE To compare rates of recovery in patients with remitted FEP after 7 years of follow-up of a dose reduction/discontinuation (DR) vs maintenance treatment (MT) trial.

DESIGN Seven-year follow-up of a 2-year open randomized clinical trial comparing MT and DR.

SETTING One hundred twenty-eight patients participating in the original trial were recruited from 257 patients with FEP referred from October 2001 to December 2002 to 7 mental health care services in a 3.2 million-population catchment area. Of these, 111 patients refused to participate and 18 patients did not experience remission.

PARTICIPANTS After 7 years, 103 patients (80.5%) of 128 patients who were included in the original trial were located and consented to follow-up assessment.

INTERVENTION After 6 months of remission, patients were randomly assigned to DR strategy or MT for 18 months. After the trial, treatment was at the discretion of the clinician.

MAIN OUTCOMES AND MEASURES Primary outcome was rate of recovery, defined as meeting the criteria of symptomatic and functional remission. Determinants of recovery were examined using logistic regression analysis; the treatment strategy (MT or DR) was controlled for baseline parameters.

RESULTS The DR patients experienced twice the recovery rate of the MT patients (40.4% vs 17.6%). Logistic regression showed an odds ratio of 3.49 ($P = .01$). Better DR recovery rates were related to higher functional remission rates in the DR group but were not related to symptomatic remission rates.

CONCLUSIONS AND RELEVANCE Dose reduction/discontinuation of antipsychotics during the early stages of remitted FEP shows superior long-term recovery rates compared with the rates achieved with MT. To our knowledge, this is the first study showing long-term gains of an early-course DR strategy in patients with remitted FEP. Additional studies are necessary before these results are incorporated into general practice.

TRIAL REGISTRATION isrctn.org Identifier: ISRCTN16228411.

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2013.19
Published online July 3, 2013.

Author Affiliations: Department of Research and Education, Friesland Mental Health Services, Leeuwarden, the Netherlands (Wunderink, Nieboer); Department of Psychiatry, Rob Giel Research Center, University Medical Center Groningen, University of Groningen, Groningen, the Netherlands (Wunderink, Wiersma, Sytema, Nienhuis).

Corresponding Author: Lex Wunderink, MD, PhD, Department of Research and Education, Friesland Mental Health Services, Sixmastraat 2, PO Box 8932 PS, Leeuwarden, the Netherlands (lex.wunderink@ggzfriesland.nl).

In naturalistic conditions, a substantial number of patients with first-episode psychosis (FEP) will stop taking antipsychotic drugs, resulting in increased relapse risk and lower rates of recovery.¹ Robinson et al² studied self-elected discontinuation in patients with FEP and found a 5-fold increase in relapse rates compared with patients who continued to take antipsychotics. In patients with multiple episodes who were receiving intermittent treatment, higher relapse rates were demonstrated compared with the rates in patients receiving maintenance treatment (MT).³ The first randomized clinical trial in patients with remission of FEP comparing MT with dose reduction/discontinuation (DR) also showed higher relapse rates and no advantages of DR.⁴ More recent studies confirmed these results.⁵⁻⁷ This further supported the guidelines stating that MT with antipsychotics is recommended for at least 1 year when a first episode has remitted.^{8,9} However, all studies on treatment strategies have a short-term follow-up of 2 years or less.^{4,10} The long-term effects of treatment strategies are therefore unknown. Moreover, treatment recommendations and guidelines are undifferentiated regarding stability and remission of the illness.^{11,12} The present guidelines are directed mainly toward the prevention of relapse. However, awareness is growing that, in addition to relapse, functional status should be included in outcome evaluation. Therefore, recovery, including both symptomatic and functional remission, would be a more adequate concept for outcome evaluation.¹³

The aim of the present study was to evaluate the long-term outcome of an early-course DR strategy on recovery compared with MT. Therefore, a 7-year follow-up assessment was conducted in a cohort of patients with FEP who originally participated in an early-course DR trial.⁴

Methods

Participants

Patients seen for the first time in mental health care services with a first episode of psychosis from October 1, 2001, until December 1, 2002 (N = 257), in a 3.2 million-population catchment area were asked to participate in the original 2-year trial comparing DR with MT.⁴ Of these, 111 patients refused to participate or were lost to follow-up, and 18 patients did not show response of symptoms within 6 months of antipsychotic treatment or sustained symptom remission during 6 months. One hundred twenty-eight patients were included in the original trial and completed it. At the end of this trial, all patients consented to follow-up. Research assistants who recruited the patients in the original study contacted them 5 years later, requesting their participation in a one-time interview regarding the course and outcome of psychosis during the follow-up period.

Assessments

Baseline data were sampled as part of the original trial. These included sex; duration of untreated psychosis (DUP); age at onset of psychosis; educational level; having a regular job for at least 16 hours a week; living alone vs with others; diagnosis

of alcohol and cannabis use, and dependence or abuse of any substance; diagnostic category of nonaffective psychosis (schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, or psychotic disorder not otherwise specified); symptom severity; social functioning; quality of life; and time from start of antipsychotic treatment to first remission. A detailed description of the instruments and measurement methods was reported by Wunderink et al.¹⁴

In the present study, the patients were followed up after 7 years, which was calculated from the start of the original trial (the start date of the first remission). The follow-up assessment included symptom severity and level of social functioning during the past 6 months, relapses during the whole follow-up period, and the type and dose of antipsychotics used during the past 2 years. Dosage data registered in patient records were verified during the assessment interviews.

Symptoms were assessed with the Positive and Negative Syndrome Scale (PANSS).¹⁵ The PANSS was used to measure observer-rated severity of symptoms during the preceding week, as well as during the past 6 months.

Social functioning was assessed with the Groningen Social Disability Schedule (GSDS), a semistructured investigator-based interview measuring disabilities in social functioning in 8 domains (7 of which were included in this study) over the past 4 weeks, as well as during the past 6 months.¹⁶ The 7 domains are self-care, housekeeping, family relationships, partner relationships, relationships with peers, community integration, and vocational functioning. The parenthood domain was omitted because of limited applicability. A disability is rated by the investigator on a 4-point scale: none (0), minimal (1), obvious (2), and serious (3).

Training for administration of PANSS and GSDS was provided for all research assistants before the study. Training included ratings of videotaped and real-life interviews, followed by discussions and review of ratings.

At baseline, predictors of recovery (symptomatic and functional remission) were recorded as part of the original trial: demographic variables, DUP, psychopathologic characteristics (PANSS), cannabis and any other substance abuse, social functioning (GSDS), quality of life (World Health Organization Quality of Life [WHOQoL]), living situation, and vocational situation. Details on the measurement of DUP and other baseline variables have been described elsewhere.¹⁴

Definitions of Recovery, Symptomatic Remission, Relapse, and Functional Remission

Criteria for recovery were met when patients had symptomatic and functional remission for at least 6 months at the 7-year follow-up. Criteria for symptomatic remission were adopted from Andreasen et al.¹⁷ All relevant PANSS item scores have to be 3 (mild) or less on a scale ranging from 1 (not present) to 7 (severe) during an observational period of 6 months. Patients were assessed retrospectively for any symptomatic relapse occurring during this period. A symptomatic relapse was defined as an exacerbation of symptoms during at least 1 week with at least 1 relevant PANSS item score above 3 (mild). Any relapse in symptoms during the 6 months preceding the as-

assessment prevented the individual from being categorized as recovered at the time of the assessment.

According to generally accepted views, functional remission implies proper social functioning in the main domains of everyday life. The 7 domains of the GSDS included in the present study adequately represent these domains. A patient with functional remission should function adequately in all 7 domains with none or only a minimal disability in any of them (not allowing a score of 2 or 3 on any GSDS domain).¹³ Patients were considered to have functional remission if, during an observational period of 6 months before assessment, all functional domain scores remained at 1 or lower.

Conversion of Antipsychotics to Haloperidol Equivalents

To compare medication use, prescribed antipsychotics were converted to haloperidol equivalents. Because of different mechanisms of action, there is no generally accepted algorithm to convert the novel or even the first-generation antipsychotics to haloperidol equivalents. We used existing dose range recommendation tables to convert the applied antipsychotic agents to haloperidol equivalents.^{9,18}

Calculation of Mean Daily Dose of Antipsychotics and Timeline of Dosing

The calculation of the mean daily doses of antipsychotics during the last 2 years of follow-up was based on registration of dosage data in patient records verified during assessment interviews. Prescription data are accurately registered in electronic patient files in all participating services in this study. First, the mean daily dose for each month was calculated, including days of zero intake, to get an impression of the timeline of dosing. The mean daily dose during the 2-year period was then calculated by adding the means for each month and dividing by 24. To obtain a more accurate impression of prescribed dosages, we also calculated the mean daily dose during the last 2 years of the 7-year follow-up, excluding days of zero intake. To get an impression of the timeline of dose reduction and discontinuation, we calculated the mean number of months per patient and the mean number of patients per month with zero intake, as well as with doses below 1 mg of haloperidol equivalents during the last 2 years of the 7-year follow-up.

Statistical Analysis

Analyses were carried out using commercial software (SPSS, version 18.0; SPSS Inc). Baseline characteristics of participants and nonparticipants and of DR and MT groups were evaluated with Pearson χ^2 tests for categorical variables and unpaired 2-tailed *t* tests for continuous variables. Selection of variables to be included in the regression models was based on bivariate analyses, Pearson χ^2 tests for categorical variables, and *t* tests for continuous variables of baseline variables and recovery, as well as symptomatic and functional remission at follow-up. The DUP was log transformed in these analyses for its skewed distribution. *z* Scores for skewness of the distribution were 13.95 for non-log-transformed DUP days vs -0.75 for log-transformed DUP days. However, the same conclusions were obtained by including DUP days in the analyses instead of the log-transformed DUP days.

Potential explanatory variables included demographic measures, baseline symptoms (positive, negative, and general), baseline social functioning, substance abuse, and DUP. Logistic regression analyses were used to study the contributions of relevant predictors to recovery and its constituents (symptomatic and functional remission) as dependent variables. Relevant variables were entered in the regression model if bivariate analysis showed a significant association ($P < .05$) with recovery, symptomatic remission, or functional remission at the 7-year follow-up. Time to first relapse during follow-up from random assignment to DR or MT groups was analyzed with a Kaplan-Meier survival analysis. The mean number of relapses with DR and MT was compared using an unpaired 2-tailed *t* test, and the cross tabulation of number of relapses and treatment arm was analyzed with a Pearson χ^2 test. The difference of the mean daily dose of antipsychotic medication during the last 2 years of follow-up between DR and MT, calculated by determining the mean daily dosage including periods with zero intake of antipsychotics, was analyzed with an unpaired 2-tailed *t* test. The same analysis was done comparing the mean daily doses excluding periods with zero intake, the mean number of months with zero intake and with daily doses below 1 mg of haloperidol equivalents per patient, and the mean number of patients per month with zero intake and with doses below 1 mg of haloperidol equivalents. Finally, we performed an as-treated post hoc analysis to compare the outcome of patients who successfully discontinued or achieved substantial dose reduction (mean daily dose <1 mg of haloperidol equivalents) determined with Pearson χ^2 . To find predictors of successful dose reduction/discontinuation of antipsychotic medication during the last 2 years of follow-up, we performed another logistic regression analysis. Relevant predictors of dose reduction/discontinuation were selected by bivariate analyses (showing a significant association with dose reduction/discontinuation) and entered into a stepwise logistic regression analysis with discontinuation or dose reduction to a mean daily dose of less than 1 mg of equivalents of haloperidol during the last 2 years of follow-up as a dependent variable.

Results

Of the 128 patients who participated in the original study, 103 patients (80.5%) were located and consented to participate in the 7-year follow-up. Of the 25 nonparticipants, 1 patient had committed suicide, 18 patients refused further participation, and 6 individuals were lost to follow-up. There were no significant differences in baseline characteristics and functional data between participants and nonparticipants in the 7-year follow-up study and also none between the 2 treatment strategy groups (Table 1).

The variable DUP has been log transformed in Table 1 because of its skewed distribution. The actual values of DUP in the follow-up sample ($n = 103$) were mean (SD), 266.6 (529.9) days; median, 31.0 days; 25th percentile, 0 days; 50th percentile, 31 days; 75th percentile, 184 days; and maximum, 3560 days (interquartile range, 0-184 days).

Table 1. Baseline Characteristics of Participants and Nonparticipants and of DR and MT Participants

Characteristic	No. (%)		Statistic	P Value	Strategy, No. (%)		Statistic	P Value
	Participants (n = 103)	Nonparticipants (n = 25)			DR (n = 52)	MT (n = 51)		
DUP, mean (SD) [median], d ^a	1.51 (1.10) [1.49]	1.39 (1.17) [1.49]	$t_{126} = -0.48$	.63	1.45 (1.13) [1.49]	1.56 (1.08) [1.78]	$t_{101} = -0.50$	.62
Age at onset of psychosis, mean (SD), y	25.83 (6.87)	24.93 (5.84)	$t_{126} = -0.60$	.55	26.26 (6.79)	25.39 (6.99)	$t_{101} = 0.64$	.52
Regular job for ≥ 16 h/wk ^b	45 (45)	12 (48)	Pearson $\chi^2 = 0.07$	.79	27 (54.0)	18 (36.0)	Pearson $\chi^2 = 3.27$	.07
Living alone	37 (35.9)	9 (36)	Pearson $\chi^2 = 0.00$	.99	19 (36.5)	18 (35.3)	Pearson $\chi^2 = 0.02$	.89
Dependence or abuse								
Alcohol	22 (21.4)	2 (8.0)	Pearson $\chi^2 = 2.36$	.12	13 (25.0)	9 (17.6)	Pearson $\chi^2 = 0.83$	.36
Cannabis	26 (25.2)	5 (20)	Pearson $\chi^2 = 0.30$	.58	14 (26.9)	12 (23.5)	Pearson $\chi^2 = 0.16$	.69
Any	37 (35.9)	8 (32.0)	Pearson $\chi^2 = 0.14$	.71	22 (42.3)	15 (29.4)	Pearson $\chi^2 = 1.86$	.17
Schizophrenia	45 (43.7)	13 (52.0)			19 (36.5)	26 (51.0)		
Schizophreniform disorder	26 (25.2)	3 (12.0)			14 (26.9)	12 (23.5)		
Schizoaffective disorder	6 (5.8)	1 (4.0)	Pearson $\chi^2 = 3.80$	.58	4 (7.7)	2 (3.9)	Pearson $\chi^2 = 7.05$	.22
Delusional disorder	12 (11.7)	5 (20.0)			8 (15.4)	4 (7.8)		
Brief psychotic disorder	3 (2.9)	0			0	3 (5.9)		
Psychotic disorder, NOS	11 (10.7)	3 (12.0)			7 (13.5)	4 (7.8)		
PANSS subscale, mean (SD)								
Positive	10.28 (3.08)	10.44 (2.43)	$t_{126} = 0.24$	.81	9.79 (2.96)	10.78 (3.15)	$t_{101} = -1.66$	.10
Negative	13.50 (5.14)	14.12 (4.89)	$t_{126} = 0.62$	.53	12.87 (4.80)	13.96 (5.51)	$t_{101} = -1.08$	.28
General	25.85 (6.53)	26.24 (6.78)	$t_{126} = 0.29$	.77	25.27 (6.44)	26.45 (6.62)	$t_{101} = -0.92$	.36
Total score, mean (SD)								
GSDS	8.46 (4.19)	8.56 (4.64)	$t_{126} = 0.11$	.91	8.48 (4.10)	8.43 (4.33)	$t_{101} = 0.06$	.95
WHOQoL	91.48 (11.50)	93.08 (15.18)	$t_{125} = 0.58$	.56	90.42 (11.21)	92.55 (11.79)	$t_{101} = -0.94$	.35

Abbreviations: DR, dose reduction strategy; DUP, duration of untreated psychosis; GSDS, Groningen Social Disability Schedule; MT, maintenance treatment; NOS, not otherwise specified; PANSS, Positive and Negative Syndrome Scale; WHOQoL, World Health Organization Quality of Life scale.

^a DUP days were log transformed because of the skewed distribution.

^b Three cases missing in follow-up sample: 2 in the DR group and 1 in MT group.

Table 2. Recovery, Symptomatic Remission, and Functional Remission After 7 Years of Follow-up

Characteristic	No. (%)		
	DR (n = 52)	MT (n = 51)	Total Sample (n = 103)
Recovery	21 (40.4)	9 (17.6)	30 (29.1)
Remission			
Symptomatic	36 (69.2)	34 (66.7)	70 (68.0)
Functional	24 (46.2)	10 (19.6)	34 (33.0)

Abbreviations: DR, dose reduction/discontinuation; MT, maintenance treatment.

Recovery, Symptomatic Remission, and Functional Remission

Recovery rates were significantly higher in patients who received DR than in those who received MT (Pearson $\chi^2_1 = 8.2$; $P = .004$). Symptom remission after 7 years did not differ significantly across the original treatment strategies of DR and MT (Pearson $\chi^2_1 = 0.08$; $P = .78$), but functional remission differed significantly in favor of DR (Pearson $\chi^2_1 = 6.45$; $P = .01$) (Table 2).

Symptomatic remission without functional remission was achieved by 38.8% of all patients (DR, 28.8%; MT, 49.0%). Functional remission without symptomatic remission was reached by 3.9% of all patients (DR, 5.8%; MT, 2.0%). In addition, 28.2%

of all patients (DR, 25.0%; MT, 31.4%) achieved neither symptomatic remission nor functional remission.

Predictors of Recovery, Symptomatic Remission, and Functional Remission

Table 3 reports the results of the bivariate analyses of associations of conceivable predictors at baseline and recovery, symptomatic remission, and functional remission at the 7-year follow-up. Recovery was bivariately significantly associated with PANSS positive symptoms, negative symptoms, general symptoms (less severe), living with others vs living alone, social functioning (better), and trial arm (DR). When entered stepwise in

Table 3. Bivariate Analyses of Conceivable Baseline Predictors of Recovery, Symptomatic Remission, and Functional Remission at 7-Year Follow-up

Baseline Variable	Recovery		Remission			
	Statistic	P Value	Symptomatic		Functional	
			Statistic	P Value	Statistic	P Value
Sex	Pearson $\chi^2 = 1.58$	.21	2.20	.14	1.22	.27
Educational level	Pearson $\chi^2 = 0.78$	.68	1.38	.50	0.59	.74
Living alone	Pearson $\chi^2 = 6.82$	.009	0.89	.34	7.36	.007
Holding a regular job for ≥ 16 h/wk	Pearson $\chi^2 = 3.06$	.08	1.07	.30	3.15	.08
DUP (log transformed)	$t_{101} = 1.62$	.11	2.41	.02	1.46	.15
Age at onset of psychosis	$t_{101} = -0.05$	.96	0.82	.42	-0.40	.69
Total score						
GSDS	$t_{101} = 2.99$	.004	1.99	.049	3.62	<.001
WHOQoL	$t_{101} = -1.34$	.18	-0.64	.53	-1.75	.08
Diagnosis	Pearson $\chi^2 = 4.61$	.46	8.14	.15	3.07	.69
PANSS subscale						
Positive	$t_{101} = 2.41$	.02	1.57	.12	2.63	.01
Negative	$t_{101} = 3.16$	.002	2.19	.03	3.89	<.001
General	$t_{101} = 2.65$	.009	1.23	.22	3.22	.002
Dependence or abuse						
Alcohol	Pearson $\chi^2 = 1.88$	.17	1.11	.29	0.79	.37
Cannabis	Pearson $\chi^2 = 0.04$	.83	0.42	.52	0.08	.78
Time to remission, d	$t_{101} = -0.32$	.75	-0.17	.87	-0.25	.80
Arm (DR vs MT)	Pearson $\chi^2 = 6.45$	.01	0.08	.78	8.20	.004

Abbreviations: DR, dose reduction/discontinuation; DUP, duration of untreated psychosis; GSDS, Groningen Social Disability Schedule; MT, maintenance

treatment; PANSS, Positive and Negative Syndrome Scale; WHOQoL, World Health Organization Quality of Life scale.

a logistic regression analysis, less severe negative symptoms (odds ratio [OR], 0.84; $P = .007$), living together (OR, 4.44; $P = .01$), and trial arm (DR) (OR, 3.49; $P = .01$) remained as variables significantly related to recovery at the 7-year follow-up.

Three baseline variables were significantly associated with symptom remission in the bivariate analyses: DUP (shorter), social functioning (better), and PANSS negative symptoms (less severe). Entered stepwise in a logistic regression analysis, only DUP (shorter) was significantly related to symptom remission at follow-up (OR, 0.62; $P = .02$).

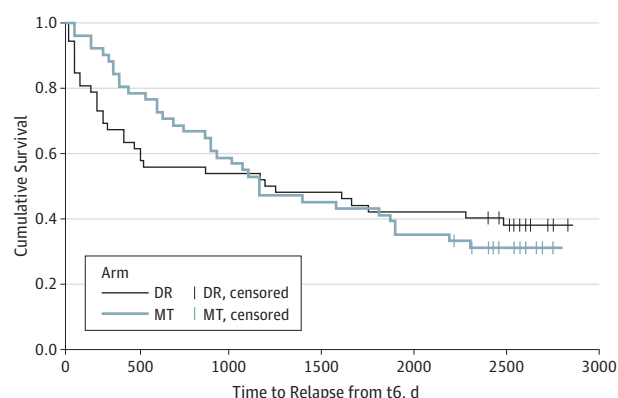
Functional remission was bivariate associated with the same variables as recovery. Stepwise logistic regression analysis showed that less severe negative symptoms (OR, 0.85; $P = .02$), living together (OR, 4.68; $P = .01$), better social functioning (OR, 0.86; $P = .04$), and treatment arm (DR) (OR, 4.62; $P = .004$) were significantly related to functional remission.

Relapse Rates During 7 Years of Follow-up

The mean (SD) number of relapses in the sample was 1.24 (1.37). Categorized by group, the mean numbers were DR, 1.13 (1.22) and MT, 1.35 (1.51); this difference was nonsignificant ($t_{101} = -0.81$, $P = .42$).

Time to first relapse from entry into the experimental phase of the trial (which was at 6 months of stable remission from baseline) was entered in a Kaplan-Meier survival analysis, comparing the survival curves of the patients who were in the DR and MT strategies (Figure 1). The initial relapse rates appeared to be about twice as high in the DR group, but the curves then approached each other and came on par at approximately 3 years

Figure 1. Kaplan-Meier Survival Analysis



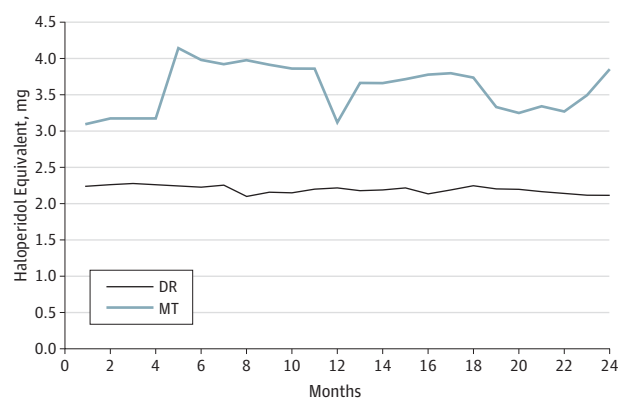
Time to first relapse after first remission (t6) during 7 years of follow-up in patients assigned to 18 months (547 days) of dose reduction/discontinuation (DR) or maintenance treatment (MT).

of follow-up. From then on, the findings were not significantly different (log-rank [Mantel-Cox] $\chi^2_1 = 0.003$; $P = .96$).

Overall, 67 of the participants (65.0%) had at least 1 relapse during the 7 years of follow-up. Categorized by group, 32 relapses occurred in the DR group (61.5% of all DR patients) and 35 in the MT group (68.6% of all MT patients).

No relapse occurred in 36 patients (34.9%), 20 of whom were in the DR group (38.5% of all DR patients) and 16 in the MT group (31.4% of all MT patients). The number of patients with a certain

Figure 2. Mean Daily Dose in Dose Reduction/Discontinuation (DR) and Maintenance Treatment (MT) During the Last 2 Years of 7-Year Follow-up



number of relapses in the DR (range, 0-5) and MT (range, 0-8) groups did not differ significantly (Pearson $\chi^2_6 = 4.96$; $P = .55$).

Antipsychotic Dose During the Last 2 Years of Follow-up

The mean antipsychotic dose (daily dose in haloperidol-equivalent milligrams) in patients originally receiving DR (2.20 [2.27] mg) remained significantly lower during the last 2 years of follow-up compared with the dose in patients who were receiving MT (mean, 3.60 [4.01] mg; $t_{101} = -2.18$; $P = .03$). The time course of mean daily doses during the last 2 years of follow-up in the DR and MT groups is graphically represented in **Figure 2**.

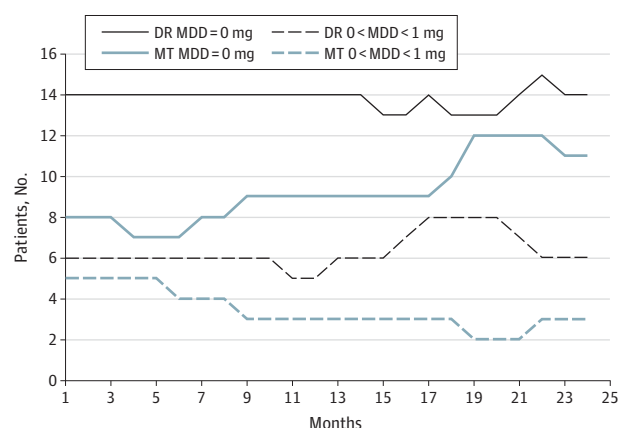
When the patients who discontinued antipsychotics during the last 2 years of follow-up (DR, 11; MT, 6) were left out of the analysis, the difference of mean haloperidol equivalent daily dose still bordered on significance: 2.79 (2.21) mg in the DR group vs 4.08 (4.03) mg in the MT group ($t_{84} = -1.81$; $P = .07$). The mean daily dose in DR vs MT patients, excluding days of zero intake to give an impression of prescribed dosages, bordered on significance: 2.89 (2.19) mg in the DR group vs 4.29 (4.01) mg in the MT group ($t_{84} = -1.98$; $P = .05$).

Discontinuation and Dose Reduction of Antipsychotics Over Time

Of the 17 patients who successfully discontinued antipsychotic treatment in the original trial, 13 were located and included in the present follow-up; 10 of these patients were in the DR group and 3 were in the MT group. Two patients (both DR) restarted antipsychotic therapy; thus, 11 (8 DR and 3 MT) patients still were not using antipsychotic agents during the last 2 years of the 7-year follow-up.

At the 7-year follow-up, an additional 3 DR and 3 MT patients had stopped taking antipsychotics during the last 2 years, amounting to a total of 17 patients who had stopped antipsychotic therapy at follow-up: 11 patients (21.1%) of the DR group and 6 patients (11.8%) of the MT group. In addition, an equal number of patients used a mean haloperidol-equivalent daily dose of less than 1 mg during the last 2 years of follow-up: 11 in the DR group and 6 in the MT group. These patients may be considered to have achieved a major dose reduction of antipsychotics. This would amount to 34 patients (33.0%) with-

Figure 3. Dose Reduction/Discontinuation in DR and MT During the Last 2 Years of 7-Year Follow-up



DR indicates dose reduction strategy; MDD, mean daily dose (haloperidol equivalent milligrams); and MT, maintenance treatment strategy.

out substantial antipsychotic medication: 22 patients (42.3%) in the DR group and 12 patients (23.5%) in the MT group (Pearson $\chi^2_1 = 4.11$; $P = .04$).

The mean number of months per patient with zero intake in the DR (6.38 [10.28]) and MT (4.35 [8.49]) groups during the last 2 years of follow-up did not differ significantly, nor did the mean number of months per patient with a mean daily dose of less than 1 mg (DR, 2.92; MT, 1.61). The mean number of patients per month who had zero intake was 13.8 (26.5%) in the DR group and 9.3 (18.2%) in the MT group, a significant difference ($t_{23} = 12.70$; $P < .001$). The mean number of patients per month who had low doses below 1 mg also differed significantly: 6.3 patients (12.1%) in the DR group and 3.4 patients (6.7%) in the MT group ($t_{23} = 9.17$; $P < .001$). The time course of dose reduction/discontinuation is graphically represented in **Figure 3**.

To explore whether discontinuation was associated with good or bad general outcome, we performed an as-treated post hoc comparison, comparing patients who successfully discontinued antipsychotics or achieved a substantial dose reduction ($n = 34$) with those who did not ($n = 69$), regardless of the original treatment strategy.

In the successfully discontinued/dose reduction patients compared with the not discontinued/tapered patients, symptomatic remission was achieved by 29 of 34 patients (85.3%) vs 41 of 69 patients (59.4%) ($\chi^2_1 = 7.00$; $P = .008$), functional remission by 19 of 34 patients (55.9%) vs 15 of 69 patients (21.7%) ($\chi^2_1 = 12.00$; $P = .001$), and recovery by 18 of 34 patients (52.9%) vs 12 of 69 patients (17.4%) ($\chi^2_1 = 13.94$; $P < .001$). The mean number of relapses in the discontinued/tapered patients during the 7-year follow-up was 0.71 (0.94) vs 1.51 (1.47) in the not discontinued/tapered group, a significant difference ($t_{101} = 2.90$; $P = .005$).

Bivariate analysis of predictors of successful discontinuation or dose reduction to a mean daily dose of less than 1 mg of haloperidol equivalents during the last 2 years of follow-up indicated no relapse occurring during follow-up (Pearson $\chi^2_1 = 7.22$; $P = .007$), treatment arm (DR or MT) (Pearson $\chi^2_1 = 4.11$; $P = .04$),

successful discontinuation of antipsychotics during the original trial (Pearson $\chi^2_1 = 23.66$; $P < .001$), short DUP ($t_{101} = 2.67$; $P = .009$), better social functioning ($t_{101} = 2.09$; $P = .04$), and less severe PANSS general symptoms ($t_{101} = 2.23$; $P = .03$). When these variables were entered in a stepwise logistic regression analysis, only successful discontinuation of antipsychotics during the original trial significantly and independently predicted successful discontinuation/dose reduction to a mean daily dose of less than 1 mg of haloperidol equivalents during the last 2 years of the 7-year follow-up (OR₁, 0.03; $P = .001$).

Discussion

To our knowledge, this study is the first to identify major advantages of a DR strategy over MT in patients with remission of FEP. In patients originally assigned to a DR strategy sustained for 18 months, after a long-term follow-up of 7 years, recovery and functional remission rates were more than twice those of patients who were assigned to MT (40.4% vs 17.6% and 46.2% vs 19.6%, respectively). There was no significant difference in symptom remission rate (69.2% vs 66.7%) between the groups.

One of the first things to consider is the selection of the sample included in the original trial. As noted, approximately half the eligible patients with FEP were not willing to participate. Compared with participants, these nonparticipants differed in showing a lower level of functioning, being less adherent to therapy, and being more difficult to engage. In the present study, one could say “the best half” of the FEP patients presenting in clinical practice was evaluated.

The major issue is, of course, whether these striking results may be attributed to the treatment strategies in the original trial. There were no significant differences in any of the conceivable confounding variables between the 2 groups. Therefore, it seems likely that the original treatment strategy, be it DR or MT, has a profound effect on long-term outcome. The difference after 7 years does not appear in the domains of symptom remission or relapse rates but in the domains of functional remission and recovery. Even though the short-term relapse rates showed a significant disadvantage of DR strategy,⁴ the long-term relapse rates did not show any significant difference, from approximately 3 years of follow-up onward. On the other hand, short-term outcome did not show any advantages of DR in the domains of recovery or functional remission, but striking differences were seen at longer-term follow-up.

A possible weakness of the present study could be the absence of rater blindness. We cannot rule out the possibility that this may have influenced the results in favor of the DR strategy, although it is not very likely to account for the magnitude of the identified differences.

Another consideration is the mechanism in the DR arm that could be responsible for the gains in functional capacity compared with MT. It was shown that even 5 years after the completion of the original trial the treatment strategies used in that study still had an influence on the dosage of antipsychotics. Successful discontinuation in the early course of FEP was sustained for many years in almost all patients and, on average, patients in the DR strategy used a lower dose of antipsychotic

drugs than did their counterparts in the MT strategy. This was mainly a consequence of a higher discontinuation rate in the DR group, but in addition, the patients in the DR group who did not discontinue their antipsychotic medication showed a trend to use of a lower daily dosage. This is in keeping with the findings of a German group.¹¹

It might well be the effect of less antipsychotic load that results in better functional capacity in the long term. Antipsychotic postsynaptic blockade of the dopamine signaling system, particularly of the mesocortical and mesolimbic tracts, not only might prevent and redress psychotic derangements but also might compromise important mental functions, such as alertness, curiosity, drive, and activity levels, and aspects of executive functional capacity to some extent.^{19,20} On the other hand, the dopamine system might play a more peripheral role in psychosis than previously thought, while hypothesized primary derangements, such as *N*-methyl-D-aspartate receptor and/or interneuron dysfunction, remain untouched by dopamine blockade.²¹⁻²³ Thus, dose reduction and, where possible, discontinuation might relieve redundant dopamine blockade, that is, not necessary to redress psychosis, and thereby improve functional capacity in the long term.

However, the psychological impact of having been in a DR strategy might have been effective. We were not able to evaluate this latter factor because we did not measure it. In the original trial we did not observe any differences between the DR and MT groups in the intensity of outpatient or community care, as well as visits to psychiatrists, community psychiatric nurses, or crisis intervention contacts.²⁴ In clinical practice, we did experience the DR strategy fitting in with the current concept of the physician-patient relationship, positioning the patient as the key player in his or her own treatment, taking the perspectives seriously, and assisting the patient in well-founded decision making on antipsychotic treatment.

Another striking finding is the flattening of the relapse rates in the DR arm after approximately 3 years of follow-up. Although relapse rates in the MT arm did not seem to level off as much, the relapse rates in the DR arm seem to have been running ahead of those in the MT group, but only for the duration of the original trial and about 1 year afterward. Maybe the MT strategy postpones the relapses compared with the DR strategy but does not prevent them. At the 7-year end point, relapse rates were not significantly different.

The results of this study lead to the following conclusions: schizophrenia treatment strategy trials should include recovery or functional remission rates as their primary outcome and should also include long-term follow-up for more than 2 years, even up to 7 years or longer. In the present study, short-term drawbacks, such as higher relapse rates, were leveled out in the long term, and benefits that were not evident in short-term evaluation, such as functional gains, only appeared during long-term monitoring. As a matter of fact, social functioning is mostly measured in a global way, for example, by means of Global Assessment of Functioning or Social Functioning Assessment Scale scores, instead of using an instrument dedicated to measuring the key domains of functional capacity. These key domains are daily living and self-care, working and studying, and relationships with others.

While in the present study we used the GSDS, a dedicated instrument for the evaluation of social functioning in patients with schizophrenia, this instrument has the disadvantage of taking about 1 hour to complete. There is a need to develop an international consensus about the criteria of functional remission and appropriate instruments to measure them. This would also result in an international understanding about the criteria for recovery in a clinical sense.¹³

The present study poses some serious considerations about the long-term benefits of antipsychotic MT following

remitted FEP and stresses the need for studying alternative treatment strategies. Apart from a guided DR strategy examined in the present study, the extended-dosing plan (administering antipsychotics with a 1-, 2-, or even 3-day interval), proposed by Remington and colleagues,²⁵ might offer a useful perspective.

Of course, only one study indicating advantages of a DR strategy in patients with remitted FEP is not enough evidence in such an important matter. However, these results merit replication by other research groups.

ARTICLE INFORMATION

Submitted for Publication: July 11, 2012; final revision received December 21, 2012; accepted December 25, 2012.

Published Online: July 3, 2013.
doi:10.1001/jamapsychiatry.2013.19.

Author Contributions: All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Wunderink, Wiersma, Sytema, Nienhuis.

Acquisition of data: Nieboer, Nienhuis.

Analysis and interpretation of data: Wunderink, Nieboer, Sytema.

Drafting of the manuscript: Wunderink, Sytema.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Wunderink, Sytema.

Obtained funding: Wunderink, Wiersma, Nienhuis.

Administrative, technical, and material support: Nieboer.

Study supervision: Wiersma.

Conflict of Interest Disclosures: None reported.

Funding/Support: This study was funded by unconditional grants from Janssen-Cilag Netherlands and Friesland Mental Health Services, Leeuwarden, the Netherlands.

Role of the Sponsors: The sponsors had no further role in any part of the study or preparation of the manuscript.

Additional Contributions: The following mental health care services within the Netherlands participated in data acquisition: Dimence (Deventer), GGNet (Warnsveld), GGZ Drenthe (Assen), GGZ Friesland (Leeuwarden), Lentis (Groningen), Mediant (Enschede), University Psychiatric Center/University Medical Center Groningen (Groningen), and Yulius (Dordrecht).

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This is a short summary of findings in her Master thesis from 2011. You will not find any references in this summary, but it is possible to get with only to ask.

“LET THE EXPERT GO”

SUMMARY OF FINDINGS IN MASTER THESIS IN FAMILY THERAPY AND SYSTEMIC PRACTICE

BY ANN-RITA GJERTZEN

Some of the most distinctive findings are summarized in this chapter. They must be seen in the context of the research questions. At the end of the chapter one can find some critical reflections about the project and some of my thoughts about what Tom Andersen would have said about this research.

The research question

The ideas for the research came from the personally experienced of discomfort. The practice with the use of reflecting team, according to Tom Andersen's theories, was described imprecisely and blended with other similar working forms or methods. I mentioned this discomfort to Tom Andersen in our last conversation. His response was that I had understood something, but he never said what was it that I had understood. This led to a commitment towards trying to come closer to a broadened understanding.

I was curious about what therapists, who had worked together with Andersen, experienced as essential to focus on, working with the use of reflecting team. The main research question was: *“Do all reflections lead to a reflecting process? What does the use of reflection as “working method” promote, according to Tom Andersen’s ideas? How do therapists describe their own and others’ qualities which, in their opinion, should be attached more importance to? What is expected from therapists using this working method?”*

Summary in relation to the research question

The central findings of the research will firstly be presented point by point. Thereafter, I will comment on the reasons why, in my opinion, these findings can be essential for work with the use of reflecting team.

The following findings have emerged as central after the analysis:

The therapists' abilities and qualities such as sensitivity, emotionality, perceptiveness, being present at the moment and ability to welcome (take in) the other's expressions. To practise is a good starting point to develop the abilities “to take notice of and to show oneself.

The reflecting co-operation as a premises for reflecting processes, is a mutual co-operation between all present. Reflection is dependent on conversations around life-world perspectives, in combination with the conversation having an explicit leadership.

"Let the expert go" and offer oneself through the therapist's offering his or her own uncertainty combined with being curious and not taking for granted that he or she understands the client's choice of words. In this way, the therapist arranges for an atmosphere which affects the human community. This involves a "not-knowing" mentality which is a conscious choice and an attitude when the therapist is listening to the words which are being said, rather than allowing the theory to guide the conversation.

The body and language of the senses: the therapist should be conscious of what is happening in one's own body and use one's "feeling of being touched" as a starting point for the words which can express the feeling and the perception through reflection. Being present in the moment and attention towards motions and changes within oneself helps one to capture expressions which have not yet been put into words.

Practice before theory: shows that the theory can overshadow the importance of the meeting on a personal level. To practise involves therapists using their own life experience and senses in meeting with clients. Practising leads towards personal confidence and security and an attitude change.

Abilities and Qualifications

The informants meant that there were expectations and requirements to the therapist. They mention sensitivity, perceptiveness, being present in the moment and the importance of showing oneself as a therapist in the therapeutic room. They refer to what they have found of essence to bring with them from working together with Andersen. It surprised me that the informants talked about that some abilities are required, and that it is not possible for all therapists to acquire this quality.

After having searched the literature connected with their statements, I do not find any "proof" that Andersen meant that there should be made any requirements to therapists. As I understand it, the informants' statements are mostly in accordance with Andersen's first publications, such as article "Reflecting Team" (1987). This means for me that the informants have been passed on these first ideas on attitude through their co-operation with Andersen.

Both Andersen (2006) and Anderson (2003) write about exploring the expressions, which one is listening to, in their various nuances and meanings. Sparks et al (2001) speak of descriptions which agree with my findings:

"..we attune ourselves to each other during reflections, listen for a theme around which we might cohere, and introduce variations, extensions, and even tones of opposition around the theme".(Ibid:116)

I mean that this way to describe work with reflecting processes and reflecting team is different from what is attached importance to within Seikkula and White's therapeutic approach. I find proof of it in Sparks et al (2001):

"Harry Goolishian proposed the term "reflecting process," which was adopted by Tom Andersen (Hoffman, 2007). In narrative therapy, the term "outsider witness group" is widely used, emphasizing the definitional ceremony metaphor described by anthropologist Barbara Myerhoff (Mayerhoff, 1986; white, 1995). We use the phrase "reflecting team" as it conveys a way of assisting each other rather than working isolation" (Ibid:115).

I mean that there is more “direction” in White’s work, the therapists interview the persons in outsider witness group. It gives less opportunity for the spontaneous feelings and expressions to come forward, when the therapist uses himself / herself as a starting point in meeting with the Other’s expressions. I mean that the humility and respect for the family’s history is not given enough space. The way, in which the therapists express themselves / their thoughts, will be crucial for the extent in which those who are listening, feel free with regard to taking with them what they find of personal importance. The informants also emphasize the therapist’s ability to welcome the other’s expressions, “show oneself”) in meeting with clients. As I understand it, the emphasis on the therapist as a person is one of the essential differences from other comparable therapy schools and therapeutic approaches.

Working with reflecting team the body’s expressions serve as a starting point for what one attempts to describe through language. A therapist choosing to use themselves and their senses as a repertoire for the therapeutic work contributes to break the rule of professionalism. This leads to a change in attitude and mentality which is perceptible in the therapeutic room.

As I understand it, the conditions for achievement of reflecting processes are mutual teamwork between all present, where everybody offers oneself in different ways, from their different positions. They meet in the attention’s room with an atmosphere which affects and touches upon human community.

The reflecting co-operation

The reflecting co-operation between the one, who is leading the conversation, and those who are sitting in the reflecting team, is emphasized as essential for arranging of favourable conditions for reflecting processes. The informants mean that the therapists must offer themselves and bring personalities to the table. Cole P. (2001) emphasizes the importance of sharing personal stories using reflecting team, as a factor which can contribute to change of earlier stories. Hertz (2010) writes that it takes courage from a therapist to not have answers to all the questions, but to offer one’s uncertainty and vulnerability through reflection. This is in accordance with my practice, experience and empirical findings.

The informants say that they, through their co-operation with Andersen, seeing him at work, grasped a fundamental attitude which they still value. This attitude is connected with what, they mean, is another condition: “let the expert go”. This is described as a “not knowing” attitude in meeting with clients. The therapists should make a conscious choice and rebel against what they describe as “the rule of professionalism”. The meeting is an exchange of different experiences. The informants say that it is easier for therapists to reflect on the recognizable, when the conversations are conducted in everyday language and around the “life-world” perspective, rather than in a profession-oriented language when therapists explore a topic in order to get answers to their suppositions about a client and his or her family. They say that it is easier to “show oneself in it” when the expressions meet through life experiences. Here, the phenomenological attitude which is created in meeting between people where mutual influence involves making the Other visible, comes into sight.

One brings about development and growth in a meeting where meanings are being created, when subjective and personal experiences meet. In my understanding, this contributes to forming the attitude, which the informants emphasize that they have got through their working together with

Andersen. They say that the fundamental values become integrated in a person because they go through the body.

The informants emphasize the importance of co-operation between the one who is leading the conversation and the reflecting team.

The informants say that the co-operation with colleagues, “learning the same” is important. In a co-operation when therapists depend on each other through interaction, and the opportunity which lies in “showing oneself. I have become aware of the confidence, which is required between colleagues. It requires that one can rely blindly on each other, lean back knowing that one will be “caught” or brought back if necessary.

“Let the expert go”

According to the informants, it is about taking a stand, putting the expert away in a meeting with people and describing the client’s expressions with dignity. The everyday language is being explored, with curiosity towards the expressions and consideration for possible cultural differences in the language and expressions. To show oneself one’s own senses and letting oneself being touched, is connected with being curious of oneself. The informants consider it being a good starting point for reflection. In my understanding, this is connected to the fact that therapists who work this way, have made a personal choice in meeting with clients. This is a meeting where one sees one’s own perceptions and feelings in connection with one’s own life. The informants meant that the ability to welcome the other’s expressions, convert it to an impression in oneself is associated with the extent in which the therapists could use themselves and their own sensitivity in meeting with the other’s expressions. They emphasize that the recognizable in the life-world perspective leads to a broader or new understanding, a reflecting process.

The body and language of the senses

The connection between being curious of oneself, one’s own emotional reactions, and using this experience of being touched as a starting point for sharing reflections, is emphasized as the most important aspect in work with reflecting processes. Attention and being present at the moment are mentioned as important factors for making notice of motions and feelings within oneself. In this way, the therapists in the reflecting team will show themselves since perception will be associated and connected with their own lived lives, I mean that there is a connection between the ability to welcome the other’s expression and showing oneself. According to the theory (Martinsen 2009), there are several ways to meet each other through language, but, as I see it, speaking from oneself as a subject is highly important when those who express themselves.

Practice before theory

Tom Andersen is known for emphasizing the importance of practice before theory. He was a doctor and a psychiatrist himself, and, for this reason, well-informed in relation to both theory and practice. The informants’ thoughts about a philosophical attitude, have led to a new way to understand his statements. According to the research, the expression has nothing to do with acquired theoretical knowledge. The informants mean that it is about the therapist’s being present in the moment, curiosity and using one’s own life experience and senses in meeting with the client’s story. They say that practising is the only way to integrate these values in an attitude. According to the informants, Andersen’s expression “practice before theory” is about taking into account that theory can limit the

therapist in making notice of the expressions. It is about practising to use the senses, listening to a conversation from a life-world perspective, rather than from theoretical suppositions (what theory tells one).

Summary

What is being promoted by this way of work? Conditions and premises for a reflecting process are mutual interaction between all present, everybody's voice is being heard. The way of work promotes an attitude of equality in a meeting with clients. This type of work is advanced through practising, and the ability to notice increases in combination with daring to show oneself as a therapist.

There are some expectations to the therapists. They must be conscious of themselves and experiences from their own lived lives. Further, consciousness of how the clients' expressions are perceived, is expected. This is taken into consideration in a meeting with one's own life experience. In a reflecting team, the clients' stories are met with the therapist's sensitivity and ability to let the story touch upon one's feelings connected to one's own life experience. In order to be able to use oneself through perceptions in a meeting with the other's expressions, it is recommended that the therapist makes a choice or calls the rule of professionalism to account.

It happens something with our understanding as therapists, when we allow the body to react. To perceive each other through the stories we tell, gives a feeling of emotional spirit of community and togetherness. Reflection of a reflecting team should be noticed. The words should be noticed, should make a difference.

Critical reflection

A challenge in this research has been to put experiences into words. It means experiences which had not yet been put into words and which had not yet been expressed?. This, in its own right, is a very difficult task – how to talk and write about something which “is not being talked about”. One of my strong qualities is to tell and describe stories from clinical practice. This quality became a hindrance during work on this thesis, because many words create problems for getting to the points, which I wanted to emphasize. Words, descriptions, explanations created confusion. It was impossible to find time and pauses for own reflection in the process of writing.

I have few informants which entails that I have not got findings / knowledge which can be generalized, which was not the intention of this master thesis either. On the contrary, I have found four informants who have shared their opinions. Their various statements give meaning to me in this context. Another critical reflection is connected to the fact that all the informants were women from the Nordic countries with health professional background. I have translated their language to Norwegian, and this can entail loss of nuances in the language. Another important point is that none of the informants were doctors or psychologists. The criteria for participation in the project were that all the informants should have co-operated with Andersen, but it could have been useful to get descriptions and opinions from professional groups with another background. I have chosen informants out of people who, as I thought, could give me knowledge.

I have also chosen a phenomenological hermeneutic method which allows to keep the informants' statements unchanged. If I had chosen another method of analysis, for example discourse analysis or grounded theory, the results would probably have been different.

My personal process

I experienced meeting with the informants as a conversation on the premises / conditions of equality. They let me take part in their experiences from co-operating with Andersen. Some of them were familiar, while other information has broadened my understanding in a significant degree. While working with the analysis, I was caught up with my own pre-understanding, and this has led to reflections on problems connected with the credibility of this research paper. "Do I find something new or do I just interpret what I see in the same frame of understanding?" I would put the material aside several times and then took it back and started anew. And, though the same uneasiness has been there all the time, it has led to increased consciousness and reflection on my role as a researcher in a familiar field.

The discomfort of researching in this field, on the ground of respect, which I have for Andersen's work, has been limiting in the beginning of the process. He did not want this way of work to be theorized, but he wanted it to be experienced through clinical practice. My loyalty towards him, as a teacher, mentor, therapist and as a person, has constituted a frame for my understanding and seemed limiting for my freedom to new thinking. However, in the process of writing, I have integrated new perspectives and broadened my understanding of what he wrote, as well as of him as a therapist.

Through trying and failing, I have put into words perceptions and undefined experiences, which, I hope, can contribute to better putting the knowledge across to students in the future. This process has led to a consciousness and understanding of the theory which has changed in step with practising in reflecting team and reflecting processes. The discomfort, which I started with, which had been shared with Andersen before he died, is now put into words and translated into increased insight for me.

New questions for future research

If I had had an opportunity to continue working on the paper, I would have taken new interviews, would have concentrated on going thoroughly into the informants' experiences from working together with Andersen. I would have expanded the selection of the informants with other professional groups than those with health professional background, would have included doctors and psychologists, for example one question could have been: how can one develop this work further? Can it be that it is not possible out of consideration for the frame, which Andersen had set? Does it mean that one has to move away from using conceptions of reflecting processes and reflecting team since those are closely connected with Andersen's main work ?

Besides being surprised over the informants' emphasis on the importance of "letting the expert go", the informants' relation to the co-operation with colleagues has given me new thoughts. In a co-operation, when therapists depend on each other through interaction, and the opportunity which lies in showing oneself, I have become aware of the confidence, which is required between colleagues. It requires that one can rely on each other, lean back knowing that one will be "caught" and brought back if necessary. Can one research on this in the future? Sparks et al (2011) writes the following:

"Ellen prophetically said it would be necessary to live each other if our enterprise was survive. As our intimacy and trust in each others grew, we were better able to listen for the potential contribution of each voice, different as it might be from our own"(Ibid:117).

What would Tom have said about this research

Firstly, he would have been pleased with the fact that clinician is writing about her work. He used to say that research is when clinicians write about their work. Then, he would have read the paper thoroughly to see whether I have treated all the informants respectfully. He would have focused on that I should not ascribe them opinions and interpret too much what they have not said. Next focus would be on the fact that the theory should reflect the attitudes and ways to relate to others which he was occupied with. In other words, respect for and acceptance of the other as a running theme in practice and theory. As I consider Research, he would have smiled and said: "Hm, Ann-Rita, is it possible for You to be at... and present this paper with the informants as a reflecting team to describe the process and what you have found?"

Andersen had moved away from reflecting team, he preferred to call the work reflecting processes. The background for it is that achievement of reflecting processes is not exceptionally reserved for work with the use of reflecting team. When I, in my research, find that he has passed on some of the "older" fundamental attitudes through practising, it creates a dilemma for me. The informants had several coincidental opinions and statements which made it probable that they had got them from co-operating with Andersen. This stands in contrast to the fact that Andersen did not want to "come with recommendations which could be understood as "commands", as he put it. I am not sure if Andersen would have liked that I emphasize some ideas above others. This is in spite of the fact that I had explained that it was important for me to find a way to describe the work for the future, so that I and other therapists can, if necessary, put into words his main work, through teaching, supervision and in this way carry ideas from his work further on.

Andersen's ideas and working method is today associated with the language systemic tradition. In the interview with Per Jensen (2006), Andersen says the following:

"Gergen (Kenneth) talks about language, almost as if it were something which one has in a drawer, and in there language lies. And then one takes it out and uses it. While John (Shotter) thinks that it is in every movement (motion?), it is connected to the body's motions (movements?). And I define language as all expressions" (Ibid:169).

I am not sure whether Andersen himself would have placed himself within the language systemic tradition, mostly because, as I understand it, language for him is more than the articulated word. This is in accordance with what the informants also imparted.

Conclusion

Andersen has passed on a way of being or attitude and mentality combined with thinking and practice which has had significant influence on the therapists whom he co-operated with. My informants have understood this as being cautious with the other's understanding of oneself, respect, equality and sensitivity in a meeting with another person.

In my opinion, the essence of what Andersen passed on with his presence is not possible to put into words. I hope that those, who have had this experience, can pass on some things of what they have perceived through and in themselves, to students and others who find working with the use of reflecting team interesting. Andersen moved away from the rules which he had made for his students and colleagues in the beginning. In my opinion, the findings show that it is necessary to bring back these rules. In the article of Sparks et al (2011), which was published during the final

phase of my writing process, I find proof of this point of view. However, it is emphasized that he himself would never have told anyone what they should do instead of something else.

"Tom Andersen, the Norwegian psychiatrist who found the reflecting team, described certain "rules" for his own comments, but declared, "I would never tell another team member how he/she should be part of a reflecting team's talk"(Ibid 116).

