OPEN DIALOGUES WITH GOOD AND POOR OUTCOMES FOR PSYCHOTIC CRISES: EXAMPLES FROM FAMILIES WITH VIOLENCE

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In Open Dialogue the first treatment meeting occurs within 24 hr after contact and includes the social network of the patient. The aim is to generate dialogue to construct words for the experiences embodied in the patient's psychotic symptoms. All issues are analyzed and planned with everyone present. A dialogical sequence analysis was conducted comparing good and poor outcomes of first-episode psychotic patients. In good outcomes, the clients had both interactional and semantic dominance, and the dialogue took place in a symbolic language and in a dialogical form. Already at the first meeting, in the good outcome cases, the team responded to the client's words in a dialogical way, but in the case with the poor outcome, the patient's reflections on his own acts were not heard.

In Finnish Western Lapland, an interesting approach has emerged that has improved the care of all psychotic crises. The entire state public psychiatric system—including both inpatient units and outpatient clinics—is organized around the idea of bringing patients together with the people in their social networks in open treatment meetings, starting with the first contact and continuing throughout the entire process. In the 1980s, in the context of the Finnish National Schizophrenia Project, Alanen and his colleagues (Alanen, 1997; Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991), in Turku, first pioneered the Need-Adapted approach. This model introduced rapid early intervention, flexible planning in response to the changing, case-specific needs of each situation, and attention to therapeutic attitude in both examination and ongoing therapy. It conceives of treatment as a continuous process, involving the integration of different therapeutic methods and constant monitoring of progress and outcomes. Operating within the Need-Adapted approach and beginning in the early 1980s, there has been a further innovation in the form of the Open Dialogue (OD). It also is based in treatment meetings that draw on the patient's existing support system. The focus of OD approach, however, is to attend to the form of communication that occurs within the treatment system composed of the mobile crisis intervention teams, the patients, and their social networks. Here, the concept of communication derives from the tradition that sees it as a forum for constituting and negotiating a positive sense of identity. It is a joint process in which new meanings are constructed "in between" people, in contrast to the view of communication as a way of transmitting something ready made from one person to another (Linell, 1998).

Current research shows that the OD approach with its emphasis on facilitating dialogue within the treatment system can be effective. Since the establishment of this new approach, the incidence of new cases of schizophrenia in this small and homogeneous region has declined (Aaltonen et al., 1997). Further, the

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appearance of new chronic schizophrenia patients at the psychiatric hospital has ceased (Tuori, 1994). In an on-going study of first episode psychotic patients, the need for hospitalization decreased, and it proved possible in many cases to compensate the use of neuroleptic medication with anxiolytics at the outset, with the results that 27% received neuroleptic medication during the 2-year follow-up period (Seikkula, Alakare, & Aaltonen, 2000, 2001*b*). This did not lead to poorer outcomes, given that 83% of the patients had returned to their jobs or studies or were job seeking, and 77% did not have residual psychotic symptoms. A possible reason for these relatively good prognoses was the fact that the duration of untreated psychosis declined to 3.6 months in Western Lapland, where the network-centered system has enabled easy access to psychiatric care and an immediate start of treatment (Seikkula et al., 2001*b*). This article describes the dialogues generated in actual treatment meetings and gives contrasting examples of "dialogical" and "monological" dialogues on the topic of family violence in the cases of two first-episode psychotic patients. A good clinical outcome appeared to be associated with the first kind of dialogue, whereas a poor outcome occurs in the second instance.

DIALOGUES IN TREATMENT MEETING

The main forum for the therapeutic interaction is the treatment meeting. Here the major participants in the problem, together with the patient, gather to discuss all the issues associated with the problem. All management plans and decisions are also made with everyone present. According to Alanen (1997), the meeting has three functions, (1) to gather information about the problem, (2) to build up a treatment plan and make all the decisions needed on the basis of the diagnosis made in the conversation, and (3) to generate a psychotherapeutic dialogue. On the whole, the focus is on strengthening the adult sides of the patient and on normalizing the situation instead of focusing on regressive behavior (Alanen et al., 1991). The starting point for treatment is the language of the family, how each family has, in their own language, observed and named the patient's problem. The treatment team adapts its language to each case according to need. Problems are seen as a social construct reformulated in every conversation. (Bakhtin, 1984; Gergen, 1994, 1999; Shotter, 1993*a*, 1993*b*, 1998). Each person present speaks in his/her own voices and, as Anderson (1997) has noted, listening becomes more important than the manner of interviewing. The therapeutic conversation resembles that described by Anderson and Goolishian (1988; Anderson, 1997), Penn (1998; Penn & Frankfurt, 1994) and Andersen (1995; see also Friedman, 1995).

Psychotic reactions should be seen as attempts to make sense of one´s experience and to cope with experiences so difficult that it has not been possible to construct a rational spoken narrative about them. In subsequent stress situation, these experiences may be actualized and a way is found to utter them in the form of a metaphor (Karon, 1999; Penn, 1998; Van der Kolk, 1995). This is the prenarrative quality of psychotic experience (Holma & Aaltonen, 1997; Ricoeur, 1992).

An open dialogue, without any preplanned themes or forms seems to be important in enabling the construction of a new language in which to express difficult events in a person's life. These events may be of any kind. They may have happened at any time, and many types of content can open up a path for a new narrative. Whatever its background, it is important to take hallucinations seriously and not to challenge the patients reality during the crisis situation, especially in the initial phase of treatment. Instead, the therapists could ask, " I do not follow; how is it be possible that you can control other people´s thoughts. I have not found myself being able to do that. Could you tell me more about it?" The other network members in the meetings could then be asked: "What do you others think of this? How do you understand what M is saying?" The purpose is to allow different voices to be heard concerning the themes under discussion, including the psychotic experience. If the team manages to generate a deliberating atmosphere allowing different, even contradictory, voices to be heard, there is the possibility to construct narratives of restitution or reparation, as Stern, Doolan, Staples, Szmukler, and Eisler (1999) named them. As Trimble (2000, p. 15) puts it, when comparing the dialogical approach to the ideas of network therapy, "Restoration of trust in soothing interpersonal emotional regulation makes it possible to allow others to affect us in dialogical

relationships." This may be one aspect of the process in which the patient and his/her social network can begin to acquire new words for their problems.

Patients often start to tell psychotic stories during the meeting at some specific point, where the most sensitive and essential themes are being handled concerning the psychosis. Acting on this hypothesis—that it is just at that point when something of the not-yet-spoken experiences are touched on—means that that point in the conversation should be brought under scrutiny. One can ask, for instance: "What did I say wrong, when you started to speak about that?" or "Wait a moment, what were we discussing when M started to speak of how the voices have control over him?" Psychotic speech thus becomes one voice among the other voices present in the actual conversation. The "reason" for psychotic behavior can be seen in the conversation at those crucial moments.

In general, the role of the team in the meeting is to allow the patient's social network to take the lead in producing the contents and to respond to each utterance in a dialogical way to promote building up new understanding between the different participants (Bakhtin, 1984; Voloshinov, 1996). Dialogue becomes both the aim and the specific way of being in language in the therapy. Instead of primarily focusing on and aiming at changing the patient (e.g., a rapid removal of the psychotic symptoms) or the family (e.g., aiming at a new interactional style within the family system), the main therapeutic efforts take place in the space between the team (and other parties) and the family or those members of the social network present. Building up a dialogical dialogue, instead of a monological one, means thinking more about how to answer the utterances produced by the patient and the family. It means being present in the actual conversation. In this sense, systemic family therapy can be seen as consisting of rather a lot of monological utterances, given that the team is using a tactic, for instance, of circular questioning, through which a change in the family system can be initiated. In systemic family therapy, it is not that important to answer every utterance, because the primary focus may be outside the actual theme under discussion.

Creating New Language for the "Not Yet Spoken"

In open dialogue, the "tactic" is to build up dialogical discourse. In dialogue, new understanding starts to emerge as a social, shared phenomenon. The individuals present at the meeting are speaking about their most difficult experiences. In terms of psychotic speech, people are speaking about things that do not yet have any other words than those of hallucinations or delusions. Once this reality can be shared, then new resources become available. What first takes place in outer dialogue in the social domain may thereafter be evaporated into an inner dialogue. Vygotsky (1970) speaks of the zone of proximal development in the child. This means the space between adult and child, wherein the adult's more developed functioning provides scaffolding for the child to reach beyond the current limits of his/her abilities. This idea can be used to describe the psychotherapeutic situation as well (Leiman & Stiles, in press). This may be one explanation why, quite often, psychotic patients are able to participate in the conversation in the first meetings without psychotic symptoms (Alanen, 1997).

One way to respond is to initiate reflective conversation (Andersen, 1995) among the team members. No specific reflective team is formed, but the team members move flexibly from constructing questions and comments to having reflective discussions with other team members. Sometimes this presupposes that the team asks for permission to do this: "I wonder if you could wait a moment so that we might discuss what we have started to think about. I would prefer it if you could sit quietly and either listen, if you want, or not if you don't want that. Afterwards we will ask your comments about what we have said." Usually the family and the rest of the social network listen very carefully to what the professionals in charge say about their problems. The reflective discussion has a specific task, because the treatment plans are constructed in these conversations. All is "transparent." Decisions about hospitalization, the motivation for medication, and the planning of individual psychotherapy are some examples of the content, and it is aimed at opening up a range of alternatives from among which choices and decisions are made. For instance in the case of a decision to opt for compulsory treatment, it seems to be important that different opinions and even disagreement about the decision can be openly uttered and discussed.

Some of the ideas pertaining to systemic family therapy (Selvini-Palazzoli, Boscolo, Cecchin, & Prata,

1978, 1980) are used in OD, but there are differences, too. Open Dialogue does not focus on the family system or even communication within the family system (Boscolo & Betrando, 1998). The aim of OD is not "to give an impulse to change the fixed logic of the system by introducing a new logic" (Boscolo & Bertrando, 1998, p. 217), but to create a joint space for a new language, in which things can start to have different meanings, as Anderson and Goolishian (1988; Anderson, 1997) have pointed out. Both OD and narrative therapies share the social constructionist view of reality (Gergen, 1994; Shotter, 1993a, 1993b), but they are different in how they see the author of the narrative. Whereas the narrative therapist aims at reauthoring the problem-saturated story, in dialogic approaches the aim is to move from monologues, which are stuck to more deliberative dialogues (Smith, 1997). In narrative therapy, the narrative has an author, in dialogical therapies a new narrative is cocreated, in the shared domain of the participants. Gergen and McNamee (2000) have termed OD as a transformative dialogue.

Open Dialogue and psychoeducational programs (Anderson, Hogarty, & Reiss, 1980; Falloon, 1996; Falloon, Boyd, & McGill, 1984; Goldstein, 1996; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996) share the view that the family is an active agent in the process. The family is neither seen as the cause of the psychosis nor as an object of treatment, but as "competent or potentially competent partners in the recovery process" (Gleeson, Jackson, Stavely, & Burnett, 1999, p. 390). The differences lie in the theoretical assumptions about psychosis. In addition to this, Open Dialogue emphasizes the meetings during the most intensive crisis situation and the process quality of building up treatment plans.

ANALYZING DIALOGUE

One aim of this article is to deepen the analysis of dialogue occurring in treatment meetings to develop the possibilities for constructing new language. The analysis takes into account communication as a joint process in identity making. The traditional qualitative methods of discourse and conversation analysis open the way to proceed in this direction, but they still have the tendency to analyze speech as a product of someone, rather than as a process in between the interlocutors (Linell, 1998). In these forms of analysis, there often is a focus on specific themes, whereas dialogue should be seen as a process. In the following discussion, there are several other studies referenced which are close to the ideas developed here.

Although narrative analysis in family therapy is a new field of research, a number of interesting studies on psychosis and psychotic speech and dialogues in family therapy have already been published. In addition, Gehart, Ratliff, and Lyle (2001) found 24 qualitative studies, of which four focused on a specific client population, as is the case in this report. Some studies have been concerned with the quality of the dialogue around the psychotic individual or family situations as well as discourse or conversation analysis of family therapy sessions. Swartz (1994) conducted a discourse analytic study of psychotic speech in context. She introduced the main research tools and some qualities of psychotic speech for each of the tools of analysis. Harper (1994) analyzed how the diagnosis of paranoia is socially constructed by experienced clinicians. He suggested that the diagnosis was constructed by a number of discursive practices and found that diagnostic judgments are constructions and these judgments are influenced by a wide variety of considerations. He was criticized by Garety (1994) and Walkup (1994) on the grounds that the sample (five clinicians) was too small to make general conclusions and that the methodology of social constructionist research was problematic. Williams and Collins (1999) conducted a qualitative analysis on how schizophrenic patients experienced their sense of self in relation to the illness and how self and illness overlap. The authors proposed a subjective theory of illness and recovery in which the core concepts were control of the crisis, identifying the individual's subjective qualities, and the role of the social network in the objective of gaining control of the symptoms. Stern et al. (1999) analyzed family members' narratives of their mentally ill relative. In stories of restitution and reparation, the relatives seemed to be searching for a platform upon which they might reconstruct a sense of personal identity and their relation to the afflicted relative. In chaotic and frozen narratives, a tendency was found to increased criticism along the lines of expressed emotions, whereas in the stories of restitution or reparation there was more space for sympathy with their relative's plight. Marley (1999) presented a model for family therapy of schizophrenic patients. The model is based on families' strengths, and narratives are constructed on the assumption that families are experts in creating their own

meaningful dialogue. All these studies illuminate the content of the experience of a psychotic patient in the family, which is a relevant part of the process.

Although not including a family of a psychotic patient, Kogan and Gale (1997; Beels et al., 1997) gave a profound description of the foundations of social-constructionist research in family therapy. They derived guidance from conversation analysis, as well as narrative- and discourse-based schools of inquiry, with the objective of analyzing a narrative family therapy session held by a prominent narrative therapist as a public consultation. The focus was on the sequential, turn-to-turn production of meaning. It was sought to ground the interpretations in the actual talk. The metaphors of "centering" and "decentering" were useful in explicating the internal rules of talk. The therapist was decentering on a number of levels. The conclusion of the analysis was that postmodern therapy might differ from other models in its decentering agenda, rather than taking a noninterventive position. As a comment on their research, it can be noted that the therapist with his various maneuvers was seen as the actor. Different ways of acting were seen as maneuvers aiming at specific goals; the difference compared to systemic family therapy thus did not become evident. In OD and in dialogical analysis, the therapist's comments are seen more as attempts to build up joint understanding, which presupposes the construction of a joint experience. So, for instance, repeating and using several different words to indicate understanding of what the wife said can also be seen as a way toward the construction of a new language, and not as a therapist's maneuvers to determine the couple's narrative.

Dialogical Analysis of Open Dialogue

The study was undertaken to develop the team's dialogue in the treatment meeting in the most severe psychotic cases. Because the team in a treatment meeting is the agent for generating dialogue, the focus was on the team members' answers to the utterances of the patient and those members of the social network attending the session. To define the differences in the quality of dialogue, a comparison was conducted between a group of good- and poor-outcome patients. This is not to say that the treatment outcome at a 2-year follow-up as such reflects only the quality of dialogue. There are many other aspects related to outcome. But the aim was to identify patients who differed enough from each other in the outcome of the treatment process.

The cases in the study are a part of a Finnish national Integrated Approach to the Treatment of Acute Psychosis (API) project and a local Open Dialogue in Acute Psychosis (ODAP) project in Western Lapland. The API project involved six research centres and the National Research and Development Center for Welfare and Health (STAKES) in conjunction with the universities of Jyväskylä and Turku carried it out. Western Lapland, as one of three centers, was allotted the specific task of organizing treatment by minimizing the use of neuroleptic medication. (Lehtinen, Aaltonen, Koffert, Räkköläinen, & Syvälahti, 2000). In the ODAP project, all the new cases in Western Lapland that fulfilled the *Diagnostic and Statistical Manual,* third edition, revised (American Psychiatric Association, 1987) criteria for schizophrenia-type psychosis between April 1, 1992 and March 31, 1997 were included. The local ethical committee gave permission for the study. Every patient was asked to give his/her consent to inclusion. Complete follow-up data for 78 patients was useable (Seikkula et al., 2000, 2001*b*).

Sample

Two groups of patients were formed: A poor-outcome group ($n = 17$), consisting of those patients whose source of living was a disability allowance ($n = 13$) or with residual moderate or more severe psychotic symptoms (rated as 2 or 3 on the Strauss & Carpenter [1972] scale, $n = 4$) and the good outcome group ($n = 61$), consisting of those patients who were working, studying, or job seeking with not more than mild residual psychotic symptoms ($n = 7$; Seikkula et al., 2001*b*). For this analysis, the aim was to find as many pairs as possible matching good outcome to poor outcome patients. The matching variables, describing the situation in the beginning of treatment, were as follows: Age, sex, diagnosis, duration of untreated psychosis, employment status, impoverishment of the social network and diagnosis of schizophrenia. Ten matched pairs were found altogether. This means the total sample for this study was 20 patients: 10 good outcomes and 10 poor outcomes.

Analysis

The objects for analysis were transcripts of the two or three first or initial phase treatment meetings. The transcripts were based on video recordings of the meetings. This article reports the "first reading" phase of the analysis. The author, who was also responsible for developing the categories for the sequential analysis, made the reading. The author knew the outcome; he could not be a neutral or objective analyzer of material external to him, but was very much involved both in developing the approach and in finding aspects of good and poor dialogue. The first reading was performed in the knowledge that a subsequent analysis by researchers unaware of the outcome of the case would be conducted after the selection of cases during this first reading.

By combining the practice of the treatment meeting with both the dialogue theories and with the research methods developed to analyze the dialogical process, a sequence analysis (Leiman & Stiles, 2001) was conducted. Sequence analysis means taking topical episodes as the main object for analysis (Linell, 2000). Topical episodes were defined in retrospect, after the entire dialogue generated in a treatment meeting has been divided into sequences. In each sequence, three variables were identified:

Dominance. The first variable was labeled as dominance of interaction, and includes quantitative, semantic and interactional dominance. Quantitative dominance simply refers to who is speaking most within a sequence. Semantic or topical dominance refers to who is introducing new content words. This individual puts most of the content into the socially shared world of discourse. Interactional dominance refers to control over communicative actions, initiatives and responses. This individual has control of other parties' actions more than the interlocutors do. (Linell, Gustavsson, & Juvonen, 1988; Linell, 1998).

Indicative versus symbolic meaning. This distinction indicates whether the words used in the dialogue are being used always to refer to some factually existing thing or matter (indicative language) or if the words are being used in a symbolic sense; that is, they refer to other words rather than to an existing thing or matter. (Haarakangas, 1997; Seikkula, 1991; Wertsch, 1985; Vygostky, 1981).

Monological versus dialogical dialogue. This distinguishes the quality of dialogue. Monological dialogue refers to utterances that convey the speaker's own thoughts and ideas without being adapted to the interlocutors. One utterance rejects another one. In dialogical dialogue utterances are constructed to answer previous utterances and also to wait for an answer from utterances that follow. New understanding is constructed between the interlocutors (Bakhtin, 1984; Luckman, 1990; Seikkula, 1995).

Procedure

First, I defined the theme sequences. At the second phase, I analyzed the three aspects of dominance, then determined whether the creation of meanings was taking place in an indicative or in a symbolic language, and whether the dialogue within the sequence was monological or dialogical. Each sequence was analyzed on a separate page on which there was also space for comments on that sequence.

The reading was done to have as many cases as needed where saturation had been reached; that is no new information for the present research objectives was forthcoming. This meant that in the studied aspects, the cases started to resemble each other within the categories of good and poor outcome. The length of the defined sequences differed in each cases read; the differences appeared to be regular in the interactional and semantic dominance; the differences in the meaning construction were clear, and the quality of dialogue differed in each case. After reading the transcripts of four poor (9 treatment meetings) and three good (7 treatment meetings) outcome cases, it was concluded that enough information existed for the first preliminary analysis of the quality of dialogue. The good outcome cases appeared to resemble each other more that the poor outcome cases, and, therefore, more poor outcome cases were read.

The third phase of analysis included going into the content of the meetings to clarify how the differences are realized in the conversation. One pair of patients appeared to show illustrative differences concerning the team's responses within the dialogue, because they both described an extreme situation of violence between family members. These were selected as cases presented in this article.

As a way of verifying the reliability of the conclusions, the analysis of the two cases was presented in a seminar to a group of therapists who were involved in the treatment processes of the research project on

first episode psychotic patients in Western Lapland. The transcripts were read in the group using overhead transparencies after changing the identifying information.

RESULTS

General Picture of Dialogue

Comparison of notes on sequences for the three categories (dominance, indicative vs. symbolic, monological vs. dialogical) shows some differences between good and poor outcomes. In the good-outcome group, sequences had a tendency to become longer. It appeared that when a dialogical dialogue was reached, the themes stayed the same for a longer time compared with monological conversation. In interactional dominance, in the good-outcome group, clients (including both the patient and the family members) dominated in over half (55%–57%) of the sequences, as against only in 10%–35% in the poor outcome cases. The patient and the family had more possibilities for control over initiatives and responses in new topics of discussion. This could be interpreted as a sign of greater possibilities to become an agent in relation to the story of their lives that was narrated in the crisis meeting. In contrast, in the poor outcome cases, this was not present during the first meetings. In terms of semantic dominance, in all the good outcome cases the family showed dominance in the majority of the sequences (70%), whereas there was more variation in poor outcome cases (40%–70%). Concerning quantitative dominance, no difference emerged between good and poor outcome patients. A striking difference emerged in the language area. In poor-outcome cases, the conversation took place in symbolic language on only a few occasions (0%–20% of sequences), whereas this was the rule in good outcomes (38%–75%). When a family had a possibility to become involved in a symbolic language area, dialogue stayed longer on a specific theme. Whereas in the case of indicative language, the team often asked questions one after another and the conversation itself remained in a question–response form. In monological versus dialogical dialogue, poor-outcome cases showed greater variation. Dialogical dialogue could occur as well (10%–50%), but it was not the rule, as it was in the three cases of good outcome (60%–65%).

Dialogue of Violence

As an example of the differences in the dialogue, two extracts of conversation follow. They occurred in the treatment meetings of two patients, and in both cases there was a situation of violence within the family that was discussed.

Good-outcome case: Reflective dialogue on violence. After the first treatment meeting at home, a father and a son had a serious quarrel concerning the son (M) who had not been taking care of his studies and was talking about vivid hallucinations and producing peculiar philosophical theories. The father did not like this and when he started to speak about them, M started to speak of his difficult experiences during his childhood. This led to a big quarrel, which ended in wrestling between father and son. Toward the end of the second meeting, this theme was taken up. In the following sequence M represents the patient, Mo the mother, TF the female team member and TM the male team member.

M: It was wrestling.
TF: But did you mean it quite seriously?
M: It was like pitting oneself against . . .
TM: Which of you was wrestling?
M: I think that he got furious.
TM: Which of you was wrestling?
TF: Which of you took hold of the other?
M: *Well, I took hold of his neck.*
Mo: Yes, and I said . . . (laughing)
M: It was a hard headlock although I have not practiced any bodybuilding. He has been doing this for several years. I have not done any sports at all, so I got a little bit frightened.
TM: (Turning towards his team-mates) Well, it is quite, it is a kind of outrage when you realize that your own child has . . .

TF: Yes, but, on the other hand, a father can be proud that his own son is so strong, that he himself was . . .

TM: Yes, but when it was directed towards himself, it cannot be . . .

TF: Yes, but he could still be proud that M is an adult man and that he is able to win in wrestling and . . .

M: Could I state a fact?

TF: I was thinking about what M was speaking of, about whether the dream is a whole one. But he is disputing with his parents.

M: But you should think yourself . . .

TF: Haven´t you heard of this kind of thing at the usual age of puberty? At the age of puberty you are disputing everything and you may have a fight to see who is going to win.

TM: So this would be a kind of . . .

TF: . . . late puberty.

TM: Quite a spurt or is it the form which is different.

TF: The form is different. And, of course, it can be quite maddening, I was thinking, when the father is a math teacher and it is a quite difficult situation.

M: Yes, and it is like the last straw when I make that two is equal to one.

TF: Yes it must´ve been the last straw.

M: He has taken that I will kill . . .

Team members seemed to be surprised when the family members started to speak of wrestling. But they listened and took it seriously. After some specifying questions and comments, they turned toward each other and started in a reflective conversation to wonder about this astonishing and frightening situation. In their reflections, they recognized the seriousness of the father–son conflict, but they also used normalizing comments. They started to question whether the wrestling could be seen as a teenage revolt and as a father's response to a teenager's revolt. The team commented on what they heard and they did so in a dialogical conversation with each other. In this sequence, M had the topical dominance, the team members the interactional and quantitative dominance, the meanings were created in a symbolic language and it was a dialogical dialogue. Overall in this specific case, in the two treatment meetings analyzed, in 57 % of the sequences the clients had the interactional dominance and in 69% the semantic dominance. Symbolic meaning construction took place in 75% of the sequences and a dialogical dialogue was reached in 65% of the sequences.

Poor-outcome case: The team does not answer. P had arrived at the hospital, where the first treatment meeting was held. In this meeting it appeared that P had been violent towards his mother. In the following sequence, this occasion is described. In the sequence, T1 refers to a female and T2 to a male therapist.

T1: I thought that it happened during the last two weeks, not before.

T2: Was it a threat or even worse?

T1: Hitting, I thought that P hit his mother.

T2: Was P drunk or did he have a hangover?

P: No, I was sober.

T2: Sober?

T1: I understood that P had tried to ask his mother something?

P: Well, it was last weekend; the police came to us. She was drunk. When she didn´t say anything and started to make coffee in the middle of the night, and I asked . . . I went out and came into the kitchen, and she turned round and said that it wasn´t allowed to speak of it. Then I slapped her. She ran out into the corridor and started screaming. I said that there is no need to scream, that why can´t she tell. . . . And then I calmed down. At that point I got the feeling. . . . And the police came and the ambulance. But in some way I have a feeling, that it is, of course, it is not allowed to hit anyone. But there are, however, situations . . . .

T1: Was that the point when you went into primary care?

P:	Yes it happened just before that.
T2:	Why did she not say that the police came?
P:	What?
T2:	Why did she not say that police had been at your place the previous night?
P:	It wasn't the previous night, it was last weekend. I was thinking, all the time I am thinking those strange things and I knew that they were not true. But when you think about them for a while, after that you have the feeling that things like that can really happen. It is too much. . . .You are only thinking of all kind of trifling matters.
T2:	And it all started last weekend, this situation?
T1:	Yes.

This discussion about a situation involving violence took quite a different form compared to the previous one. When the patient was describing the situation in confused language, unable to use unambiguous description, he ended by saying, "it is not allowed to hit anyone." He had an origin of an inner dialogue to deal with what he had done. But the team did not respond to this, but, instead, continued by questioning him about how he contacted the health care system. This was not an isolated example, given that in the next utterance, when the patient continued his self-reflection on his "strange things" (meaning hallucinations), the team did not help him to construct more words for this specific experience he was speaking about. In this short sequence there were two utterances, which were not answered, and consequently no dialogue emerged. In this sequence, the team members had both topical and interactional dominance, whereas P had the quantitative dominance. Meanings were created in indicative language and it was monological dialogue. Overall, in the three treatment meetings analyzed for this case, in 25% of the sequences the clients had the interactional dominance and in 60% the semantic dominance. Symbolic meaning construction took place in 10% of the sequences and a dialogical dialogue was reached in 15% of the sequences.

DISCUSSION

The main purpose of this article was to present preliminary evidence on which to evaluate the nature of open dialogue in treatment of psychotic problems, focusing especially on the treatment meeting. The quality of the dialogue in the treatment meetings of good- and poor-outcome patients was compared. The main findings were that, in cases of good outcome, the patient and his/her social network dominated the interaction in the meetings; they were most likely to speak in symbolic meanings instead of indicating factually existing things in their environment; and more often the sequences of dialogue took a dialogical form. These differences were illustrated in the two examples of dialogue concerning family violence. In the good outcome case, the team answered the family's surprising information about the violent event by maintaining a dialogical conversation in a form of the team's internal reflective dialogue. In the poor outcome case, the team did not answer the patient when the latter started to speak about his own responsibility and even of his psychotic "strange things."

The aim of this article was not to give any causal explanations. Thus, the results should not be seen as offering explanations for good versus poor outcome, because there were plenty of other things involved in the treatment that were not described here. The analyses should be seen as one way to proceed in developing the quality of therapeutic dialogue in the meeting. This is shown by an analysis of differences in the three variables studied in the sequence analysis, and by a specific illustration of team dialogue in an extreme situation, namely concerning the discussion of a violent incident. In accordance, there is evidence here that the quality of dialogue may be influential in the outcome, although not the only factor and it should not be offered as a complete explanation.

The general sequence analysis showed that in the meetings, the team's task is to allow the network to take the lead and dominate what should be spoken about and how. If the clients have the possibility to construct symbolic meaning, the process more easily takes a form that encourages language to be constructed for the most difficult experiences. In such circumstances, the dialogue may take on a dialogical form, a form of joint deliberation on the important things. This type of dialogue no longer resembles the

classical form of interviewing clients to obtain information on the basis of which to draw conclusions and plan interventions. The form of the dialogue itself becomes "intervention," where the team's task via dialogical answers is to generate more space for joint dialogue. The subject of the "intervention" is the dialogue itself, not the patient or the network around him/her.

The team's actions are related to what is taking place during the meetings. If the team listens to what the clients are saying and answer in a dialogical way, the clients—including the patient and the social network—are given the possibility to learn from their own sayings. As was seen in the example of dialogue in the good-outcome case, the patient in his inner dialogue was actively engaged in following the team's reflective conversation. He was commenting throughout and trying to create words to his ideas as well. It is easy to imagine that in this type of atmosphere enough security will be guaranteed to proceed to the not-yet-spoken experiences. They are not sought in a ready-made but hidden past, but they are jointly constructed and lived through in dialogue.

With the dialogue in the poor-outcome case, the situation was very much the opposite. The team did not answer the patient's attempts to have words either about his violence towards his mother or about his psychotic strange thoughts. In this sequence he was not heard, which did not support him to proceed further in his inner dialogue about these most difficult issues. Although it may have been possible to discuss these things afterwards, in this episode his own initiatives to reflect his own responsibility in hitting his mother, and in reflecting on the psychotic ideas were ignored. It can be suggested that after he did not receive any response to this own reflections, it increased uncertainty about which of his experiences were worth talking about and of importance. The team, as such, acted adequately. The therapists tried to obtain information about what had happened and how the contact with care was established. Starting to speak of violence after an adult son has hit his mother is, of course, a very sensitive and emotionally provoking subject for the therapists. In such situations, it is more difficult to be alert to the dialogue or even know what it is best to answer at that point of discussion. The present analyses appear to confirm what was said in the introduction: Listen to the words the client is speaking and answer his or her concerns rather than your own.

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