

Open dialogue: offering possibilities for dialogical practices in mental health and psychiatric nursing

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Abstract

Purpose – *The purpose of this paper is to stimulate discussion within mental health and psychiatric nursing as to how the open dialogue approach can contribute to their work. The paper is mainly theoretical, though relates to practical examples of open dialogue in mental health care research and practice to illustrate the actual potential in practice.*

Design/methodology/approach – *First the authors raise issue with the narrow lens of psychiatric diagnosis and question its usefulness against a contemporary backdrop of personalised care and recovery orientated practice. Open dialogue as a way of being and as a process are explored as they relate to people interaction and contribute to therapeutic interaction, organisational and community development. The authors reflect on how open dialogue can be and is practiced in different ways and at different levels.*

Findings – *The authors consider open dialogue as a suitable approach for working with people who have mental health and/or psychiatric problems. The approach is also recommended for working in larger circumstances as families and social network, on organisational and community levels in different ways. Open dialogue should be considered not as a method or technique but as a process of interaction which can be applied to different conditions and circumstances.*

Originality/value – *Within mental health discourse open dialogue is increasingly evident and filtering into the broader discussion on increasing effectiveness of mental health interventions. Perfectly suited to mental health and psychiatric nursing as a way of being with service user, this reflection on open dialogue offers further thoughts on how as a process it has already filtered into nursing practice and how as nurses we can easily accommodate it within the therapeutic approach.*

Keywords *Psychiatry, Dialogue, Mental health promotion, Nursing role*

Paper type *Conceptual paper*

Introduction

Open dialogue as a form of open communications; a therapeutic process; and as a process for organisational/community development has a long standing tradition, inclusive of the mental health arena. One of the crucial strengths of open dialogue is the capacity for people engaged in this process to take on board multiple perspectives, to internalise these and to work with whoever they are engaged with to form mutual realities and possibilities. This is particularly relevant to the work of psychiatric/mental health nurses. They are frequently working in environments where perspectives on health and ill health are diverse, often polarised and at odds with each other.

The impetus for this paper evolved from a, open dialogue symposium at the European Psychiatric Nursing HORATIO festival in Sweden 2012 and a follow up joint key note

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presentation at the European Mental Health Nursing Conference in Turku, Finland 2013. Here, examples of working with an open dialogue approach in mental health/psychiatric nursing were presented and practice options explored. Although this paper is predominantly conceptual it draws on the author's research and their own lived experiences as psychiatric and mental health nurses.

Open dialogue has been described in several though similar ways. More often authors are drawn to Bakhtin's (1981) view of dialogue: "as a joint action that joins people together in a temporary mutual world experience. Participants have to be willing to engage in this dialogue or a situation needs to be created where it can ensue", as an illustration of open dialogue. This view forms the baseline definition for this reflective discussion. For some, open dialogue can be regarded as being an attitude towards another person's way of viewing the world and reality and accepting the others point of view which often differs from one's own understanding (Holma and Aaltonen, 1997; Laitila, 2004).

Within service provision, according to Seikkula *et al.* (2003) the main principles of open dialogue in treatment and nursing settings are as follows:

- The provision of immediate help: the first meeting should be arranged within 24 hours of the first contact, made either by the service user, a relative or a referral agency.
- A social network perspective: the service user, their families and other significant persons from the service users' social network are invited to the first meetings.
- Flexibility and mobility: these are guaranteed by adapting the therapeutic response to the specific and changing needs of each case, using the therapeutic methods which best suit each case.
- Responsibility: the person among the staff who is first contacted becomes responsible for organising the first meeting, in which decisions about treatment are made. The team then takes charge of the entire treatment process.
- Psychological continuity: the team is responsible for the treatment for as long as it takes in both outpatient and inpatient settings. Members of the service users' social network are invited to participate in the meetings throughout the treatment process.
- Tolerance of uncertainty: building a relationship in which all parties can feel safe enough in the joint process strengthens this. It is of importance that the team members can tolerate their own uncertainty and when managing to do so, the service users and families becomes empowered and can tolerate uncertainty in a better way. Tolerance of uncertainty can be seen as an active attitude among the therapists to live together with the network aiming at a joint process instead of the treatment being more often a reaction to situations.
- Dialogism: the focus is on creating dialogue since the dialogical conversation is seen as a forum where families and service users have the opportunity to increase their sense of agency in their own lives.

Moving from a narrow interpretation of mental health problems

Within psychiatry there are multiple discourses on how people become mentally unwell and concerning authoritative and ritualised models of treatment and care. The anti-psychiatry movement has directed critique towards biological explanations of mental illness (Laing and Esterson, 1964; Laing, 1985). They criticised diagnosis as being vague and leaving too much room for opinions and interpretations. Kapiala (2003) concluded psychiatric diagnosing is more like an art than science and being much too dependent on the person making the diagnosis. Evidence-based research claims that mental health problems are brain diseases but this evidence is a result of biological research considering the biological dimensions of people. According to nursing or caring theories human beings have biological, psychological, social and spiritual dimensions (Barker, 2001; Eriksson, 1997; Hummelvoll, 1996; Paterson and Zderad, 1988). In light of those theories we can argue that it is only through a reductionist view of human beings that their essence is dependent on biological processes in the brain. Much had been

written about mental health problems but so far there is no conclusive evidence of what causes the problems. Medical and biological research is the most “politically powerful” research today and it claims that there must be evidence in all research (e.g. Essock *et al.*, 2003). One problem with this approach is that all issues in human life cannot be researched by doing only randomized control trials. However, there are also voices which challenge this view by questioning if the evidence-based medicine view can be applied to psychiatry (Gupta, 2007). Another problem is that when one does biological research, one gets biological results and biology does not clarify a human being as a whole. Another issue in psychiatric care and treatment is where often mental health professional’s interpretations, including nurses, are most often based on theoretical assumptions concerning the imagined origin of a person’s problems and difficulties (e.g. McGrath and Dowling, 2012; Vuokila-Oikkonen, 2002; Nordt *et al.*, 2006). Arguably this is no more informed than the reductionist biomedical view.

The “Age of Recovery” offers an alternative discourse to a biomedical one that encompasses the whole human being, (Roberts and Wolfson, 2004; Kartalova-O’Doherty and Tedstone Doherty, 2010). Out of the professional literature we have a seminal account of Recovery where Anthony (1993) defines recovery:

[...] as a deeply personal, unique process of changing one’s attitudes, values, feelings, skills and roles. Recovery involves the development of new meaning and purpose in one’s life beyond the catastrophic effects of mental illness (cited in Roberts and Wolfson, 2004, p. 39).

A more personalised account from the voice of experience is offered by Deegan (1988) who argues that:

[...] our recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find that our personal limitations are the ground from which spring our own unique possibilities. This is the paradox of recovery, i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can be (p. 14/15).

Making meaning out of and responding to mental health problems has moved way beyond the reductionist understanding, becoming part of peoples life stories and those they connect with and offering hope for optimistic futures. For mental health nurses it has become necessary to consider our historical understandings, our perceptions and how we engage with new possibilities and other realities outside the psychiatric paradigm.

The following case example offers insight into how perceiving a service user’s experience differently can impact on both theirs and professional’s view of their presenting problems.

A woman of 30 years age participated in a treatment meeting with friends and staff from social services and psychiatry. She had been psychiatric a psychiatric service user for about ten years and had different diagnoses: ADHD, depression and psychosis. Before becoming a service user she lived a creative life, studied successfully and was planning a family. However, she was in a car accident, got badly injured and become a service user within psychiatry. The conversation at the beginning seemed to be as conversations usually are within psychiatry. Professionals mostly wanted to convince her that all the treatment and services she had were good for her and she needed to visit all the caring and services recommended. After some time a nurse, asked her “what are those diagnoses you mentioned for you, could you describe them in your own words”. The woman was quiet for some time and said: “I don’t know, I just have them” and pointed to her head as if the diagnosis were living inside her. The conversation continued as usual. After some time the nurse asked her again the same question and the woman looked at the floor for a few minutes and raised her head saying. “ADHD for me is creativity, depression is looking back at my life and psychosis is sorrow”. These personal words made the conversation change, it became a wondering discussion about her life mainly from her point of view, perhaps it became something we can call dialogue among many different voices.

Traditionally this conversation would have continued within the mode of diagnosis and the narrative of treatment would have followed a designated pathway informed by a “predetermined perspective on mental illness and subsequent patography”. Instead a dialogue ensued; perhaps because of an increasing acceptance of diverse perspectives; or openness to diversity that takes mental health professionals beyond culturally determined unilateral psychiatric practices.

Ways of being in dialogical communication

Dialogue is sometimes nearly given the same meaning as conversation. Bohm and Peat (1987) regard dialogism to differ from conversation in a significant way. In a conversation people most often have relatively rigid points of view and they argue from these to get the others to change their own points of view. At best, this kind of conversation leads to compromise but it does not generate anything new. They argue that the meaning of dialogue is to disclose our thoughts, their incoherence and discrepancy. The idea of dialogue is to reveal the incoherent in our thoughts. When we are able to reach that we also can establish a genuine and collective consciousness, dialogue is about awakening. Dialogue is not regarded as a method, intervention or technique but an attitude or a way of relating to others.

Buber (1993, 1997) talks about two pairs of words when describing dialogue. I – it pair refers to subject to object relation in which I is subject and It an object to I's actions or behaviour. I – thou pair is a subject to subject relation where two subjects act as equals. In such relation no part is more important and no part has more power than the other. When applying Buber's position to mental health research, traditionally the I – it relationship exists where service users are more often the objects of research as opposed to actively engaged in the inquiry (McGowan *et al.*, 2009). The same can be said for the application of the externally derived evidence-based practice that does not apply I – thou and subsequently there is a distortion between professionals views of effective practice and that of service users (Faulkner and Thomas, 2002). In either case the power relations are unequal and I – it relations prosper, a state according to Buber that more generally prevails.

Gadamer (2004) hermeneutic philosophy looks to interpretations of spoken or written words and language. In dialogue we try to understand another person and what his/her speech is about. Gadamer's idea of dialogue can be associated with the idea of social construction (Berger and Luckmann, 1966) according to which there is no absolute truth or description of reality; all persons have their own construction about phenomena and the world. In hermeneutics people interpret what something is about and so it is also according to social constructionism. These interpretations are kinds of social constructions and so, one of the main ideas of dialogue is not only to listen to the other but also listen to yourself, your inner voice. Dialogue involves also a dialogical relation to oneself, an inner discussion during which one interprets his/her own thoughts.

Bakhtin (1984) posited that participants in a dialogue must be willing to engage themselves in a dialogue, a joint action that puts people together in a temporary mutual experience of the world. If such occasions are not possible they must be created.

If we consider this brief synopsis of dialogic engagement, the optimum way of being in a relationship could be as subject to subject, with shared expertise of being in the world (Heidegger, 1996), in pursuit of mutually understood and agreed reality or outcome of the dialogue.

Open dialogue as a process

Open dialogue has its theoretical background in social constructionism according to which there is no single truth or explanation of reality (Berger and Luckmann, 1966). If we consider mental health problems as objects for explanation they cannot have a simple but have multiple explanations depending on who is trying to understand them. Shotter (1997) argues that open dialogue is spontaneously occurring activity, a space for social constructions, where mutual truth can be created between people. Stern (2004) agrees with Shotter when emphasising the importance of the present moment which can be regarded as moments that include a dialogical dimension since in those moments two individuals seems to constitute a joint space and understanding without words. Stern proposes moving from explicit knowledge to implicit knowing that happens in the present moment as embodied experience. This implicit knowing happens in between the nurse and the service user by words and without words by experience for them both. They are joint experiences between persons whom are not "hidden" behind their role as nurse or a service user but as two subjects experiencing something common. It is in the response and responsiveness of a person to another person before anything is put into words or

described in language. In the Finnish tradition of family therapy (Alanen *et al.*, 1991, 2000) open dialogue focusses on generating dialogue between and within systems. This can be understood as shifting the focus from what the narratives are about to the actual situation when narratives are told and experiences in and of the present moment. Nurses and service users live in a joint “being together” as Paterson and Zderad (1988) describe it. In that kind of dialogues, an intersubjective consciousness emerges and that can be seen as being in a dialogical relationship (Buber, 1993). Our social identity is constructed by adapting our actions to those of others; and even more, knowing oneself as such is only possible by me seeing myself through the eyes of the other.

The case for open dialogue in mental health nursing practice

Open dialogue may not apply to certain ways of engaging in psychiatric or mental health care, especially when the treatment system is strongly influenced by medical and/or biological expertise. There has been an ongoing debate relating to both the title of and practice of “mental health” or “psychiatric” nursing. The general argument outside of educational branding relates to the ideology, socialisation and disciplinary alignment that nurse’s shift towards (Du Mont, 2006; Chambers, 2006). Those that shift towards health promotion are mostly working in the community and more likely to relate to “mental health nursing” (Chambers, 2006). Whereas, those aligned to psychiatry with a disease orientation are more likely to relate to “psychiatric nursing” (Du Mont, 2006). The authors of this paper argue that there are possibilities for nurses to engage in open dialogue as a way of relating with service users and mental health team members. A major challenge for those choosing to engage more therapeutically arises where nurses are embedded in systems subsumed by the psychiatric discourse. In such systems there is an inextricable entanglement of psychiatry, psychiatric nurses and service users that have taken “psychiatric identities” (Roberts, 2005; Mac Gabhann, 2014). Such systems contradict the very nature of dialogue. As mental health policy became increasingly coercive nurses were required to follow suit in practice (Hannigan and Cutcliff, 2002); nurse’s roles in institutional settings became that of control and restriction of civil liberties (Hall, 2004). The psychiatric discourse rests on the subjectification of people with mental health problems with “psychiatric identities” where a dependence on the system and loss of personal control are keys to the management of mental illness (Roberts, 2005). The disempowerment of psychiatric service users provides a mechanism for the concurrent empowerment of psychiatric nurses and in that they have absolute power over service users (Perron *et al.*, 2005; McGowan *et al.*, 2009; Lakeman *et al.*, 2012a, b). It has been argued that mental health and psychiatric nursing should be considered as being based on humaneness and not only the professional’s way of structuring the reasons for mental health problems (Piippo and Aaltonen, 2004, 2008; Söderlund, 1998; Hummelvoll, 1996). However, people diagnosed as suffering from mental health problems experience themselves as being objects for professional’s actions (Topor, 2001; Whitaker, 2002). For example, Vuokila-Oikkonen (2002) and Webb *et al.* (1998) argue that service users within psychiatric care wish to involve their relatives in discussions concerning their treatment process. Piippo and Aaltonen (2004, 2008, 2009) has shown that treatment in which the service users relatives and members of their social network are included and which includes open dialogue increases trust and experience of safety among the service users, relatives and professionals. Piippo and Aaltonen (2008) concludes that in psychiatric treatment, the symptoms or imagined illness, living inside the patient, should not be the core for care; instead it should be about relations between service users, relatives, members of the social network and professionals.

Dialogical practice creating a dialogical space for mental health nursing

The very nature of mental health service provision and organisational infrastructures influences nurses in a way that may hinder their capacity to engage in open dialogue. The settings can impact on the extent that nurses choose to relate to service users as fellow human beings. However, nurses themselves can choose how they relate whilst they try to reconcile the “mental health” and “psychiatric” aspect of their role. Open dialogue can and is practiced inside and outside of mental health settings, and mental health nurses are often champions in creating

dialogical spaces for this dialogue to ensue. Although, engagement in open dialogue ranges from therapy, through research, organisational change and community development the core theoretical underpinning of open dialogue applies to all. The following examples suggest that open dialogue has a suitable place in the advancement of mental health nursing and practice.

In practice

During a one year Participatory Action Project nurses and inpatients on an acute inpatient ward were exploring how they could and subsequently did engage in more therapeutic relationships (Mac Gabhann, 2008). During the research process participants experienced challenges such as: power imbalances; routinized engagement, different perceptions associated with patient presentations and meanings attributed to their experiences that affected their capacity to engage in meaningful dialogue around the aims of the research inquiry. A solution was found in the formation of open dialogue groups where participants learned to engage in open communication and the normal infrastructural challenges were overcome. Thereafter the groups became the mechanism for both achieving the aims of the inquiry and participants engaging in open dialogue. Although the intention of these groups was to facilitate the research process a byproduct was the transformation in how inpatients and nurses interacted with each other. The cross-over and often blurred boundaries between research and therapeutic activity is recognised as a positive outcome of practice research (Jorm *et al.*, 2007; Lakeman *et al.*, 2012a, b) and this is particularly the case in participatory action research (Koch and Kralik, 2006).

Organisational change

In 2007 as a response to recent Irish mental health policy (Government of Ireland, 2006) that required all service design, development and delivery to be underpinned by a tripartite partnership of service users, family carers and professional providers; a mental health leadership programme was devised. The programme was developed in association with the International Initiative for Mental Health Leadership and from a partnership of Dublin City University, National Office for Mental Health, national service user and carer groups and participating local mental health services. The three processes underpinning the programme were: co-operative learning; participatory action and open dialogue (Mac Gabhann *et al.*, 2010). In summary, service users, carers and professional mental health providers sponsored by mental health services participated in an action orientated programme that culminated in a local service improvement. Over half of the professional providers engaging in this programme were mental health nurses. From the outset team members and the larger group engage in learning process facilitated through open dialogue. Open dialogue then becomes the means of creating a communicative space in the community (Habermas, 1987). Over nine years there has been a cumulative effect in participating organisations where there are small pockets of service delivery that are underpinned by an ongoing process of open dialogue in relation to service development and decision making.

Community development

The Mental Health Trialogue Network Ireland (IIMHN) (www.trialogue.co) was established in 2010 as a community response to persistent difficulties in how service users, carers and mental health professionals communicated within mental health services. Initially seven communities around Ireland established monthly "Triologue Meetings". A Trialogue Meeting is a community forum where anyone with an interest in mental health participates in an open dialogue. Trialogue meetings are welcoming and inclusive of all community members, including service users, carers, families, friends, professionals and anyone with an interest in mental health in the community (Mac Gabhann *et al.*, 2012a).

The first Trialogue Meetings emerged in the early 1990s following the World Conference for Social Psychiatry in 1994. Trialogue Meetings became established in Germanic speaking countries Germany, Austria and Switzerland with over 5,000 people participating regularly by 2002 (Amering *et al.*, 2002). Although stimulated by critical discussions at the world conference there had been a growing discontent with professionalised approach to care and a recognition that

service users and families needed to be involved in determining the future of understanding and responding to mental distress if better solutions to psychiatric care were to be found. Crucially these meetings take place on neutral ground under special conditions, outside family, institutional or therapeutic settings and it would appear that they are becoming part of a stable discourse in the evolution of mental health care in many countries including Ireland (Mac Gabhann *et al.*, 2012b).

Conclusions

Our attempt with this paper in integrating theoretical and practical applications of open dialogue, is to extend a discussion among mental health and psychiatric nurses concerning choices they can make. The choices should be personal choices which nurses make in their inner dialogue but also as a nursing community. The questions that may be discussed relate: to the perspectives on mental health problems we engage with; to what guides the mental health or psychiatric nurse in their work; and to how open can one be in a nursing relationship, for example, can one handle multiple explanations of a person's problems, the role of service users and family members as experts in their situation. One way nurses can choose is a narrow way, which does not allow them to think broadly but according to traditional biomedical ideas concerning mental health and psychiatric problems. Or they can choose a way that invites them into dialogical interaction with service users and their significant social network. However, this might be a challenge for nurses. Having an open dialogical way of working requires change in thinking and relating to one's work and to service users. An open dialogical way of working also requires support from colleagues and leaders in an organisation. Trust between carers and service users is of importance and open dialogical ways of working gives more possibilities to development of trust than treatment as usual.

Our contention is that mental health/psychiatric nurses roles would be enhanced if they always have an orientation that the service users human environment as a natural part of dialogical interaction. When psychiatric treatment and care is organised so that family members and the social network are included in the treatment process, it becomes possible for the personnel to use their individual expertise appropriately. Concerning dialogical attitude, psychiatric and mental health nurses may become more aware of their own thoughts during the treatment process, and be willing to change them. This is, according to our understanding, possible only when nurses can openly reflect and discuss together with service users and their relatives concerning their thoughts. Then it also becomes possible for the service user and their significant others to verbally reflect on the nurses thoughts. In this kind of dialogical interaction, all possible social constructions concerning people's mental health problems become open material for consideration.

Open dialogue offers a forum for this kind of work where the main aim is to create shared understanding concerning any given situation and what can be done to make the situation better. The shared understanding should be the "thing" that guides the treatment and not theoretical assumptions based on medical, biological conclusions or psychological conclusions. Open dialogue also offers us a new lens to a world of mental health and psychiatric problems as well as a platform for innovative solutions. It also offers the service user and his/her significant others new ways of viewing their life situation.

We have illustrated that open dialogue is not limited simply to nurse patient relationships and can be applied to family, social, organisational and community development. Of course particular models and respective training have evolved within the discourse and whilst not diminishing the importance of models and training, open dialogue as a way of being and of relating in our experience is as much of a personal and cultural shift in perspective as anything more formalised or applied. In such circumstances it becomes possible to discuss issues in such a way that all of the players in the community of mental health have an opportunity to influence how mental health care is developed and delivered. However, even if the author's personal experiences illustrates that open dialogical practices are possible and useful, all nurses are not necessarily comfortable with it. It is a personal and opportune choice for each nurse and professional whether they want or not to engage in open dialogue.

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