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Dialogical Features, Therapist Responsiveness, and Agency in a Therapy for Psychosis

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This study aims to further theoretical and clinical discussions regarding the therapy of psychosis from a dialogical perspective and to contribute to the contemporary research literature that works toward developing methods for studying the dialogical processes in therapy. Three videotaped sessions of a therapy with a heterosexual couple, in which both partners had psychotic experiences, were analyzed using the Dialogical Investigations of Happenings of Change, a method developed with an aim to capture the dialogical qualities of multiactor conversations. The analysis illustrated shifts in the dialogical characteristics of the conversation through the sessions and associated shifts in the clients' positioning, toward increased agency, as well as enrichment of the narratives regarding their difficulties. The gradual development toward more dialogical conversations, evidenced mainly in increased sharing of dominance and therapist responsiveness and participation, seemed to facilitate the joint construction of new words and meanings, the expression of strong feelings, the narration of difficult experiences, and increased agency. The findings support the view that a client's sense of agency, which can be particularly impoverished in psychosis, can be reconstructed in the context of dialogue, in which clients have a central place in telling their story.

Over the last decade, there has been a growing interest in the experience of psychosis as well as in the role of psychological therapies in recovery. This article aims to contribute to the clinical literature on the therapy of psychosis from a dialogical perspective, as well as to the research literature that works toward developing methods for studying psychotherapy from a dialogical perspective. In recent years, dialogical theory has become increasingly important in conceptualizing human experience, selfhood, and social life (Linell, 2009). In the field of mental health, it has been used as a framework for conceptualizing both mental distress and the process of therapy (Anderson, 2012; Hermans & Dimmagio, 2004; Salvatore & Gennaro, 2012; Seikkula, 2011). With regard to conceptualizing psychosis from a dialogical perspective, we start from the premise that it is important to see the active psychological quality of psychotic behavior and to try and understand its meanings, rather than approaching it, as is often the case, solely in terms

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of pathology, dysfunction, or lack. In this framework, hallucinations, for example, are considered part of the human psychological variations of behavior that arise primarily in extremely stressful situations. Moreover, psychotic behavior is seen to have a strong embodied element. Louis Gould, for example, noted as early as 1949 subcortical movements in the vocal cords of patients with hallucinations. This finding has not been fully supported in further studies (Green & Kinsbourne, 1990), but there is evidence that embodied action through subvocal activity, such as humming, can reduce auditory hallucinations; also, there is evidence that hallucinations have similar effects on the auditory cortex activity as real sounds (Tiihonen et al., 1992). Furthermore, van der Gaag (2006) observed that hallucinations are associated with activity in similar brain functions as those active in imagination. Moreover, several important bodily functions have been observed in the context of hallucinations, as well as other forms of psychotic behavior, which are similar to those observed when faced with traumatic experience (Seikkula, 2002). In line with this, there is growing evidence for the role of trauma in psychosis. Given that many people with psychosis have experienced violence early in life, psychotic experiences have been described as resembling trauma-related dissociative experiences (Kilcommons & Morrison, 2005; Read, van Os, Morrison, & Ross, 2005; Shevlin, Dorahy, & Adamson, 2007). As several authors (e.g., Dell & O'Neil, 2009; Howell, 2005; van der Kolk, McFarlane, & Weisaeth, 2006) have argued, intensely traumatic experiences are inscribed implicitly, which means they cannot be put into words but are, rather, reexperienced or enacted. From this perspective, extremely stressful current situations, which resemble in some way intensely painful or frightening early experiences, may trigger a psychotic response by the embodied mind. One could say that in psychotic behavior, the body talks through metaphor, "narrating" and enacting the person's story. People in their hallucinations describe real events and experiences, even though the way these are described may be confusing, so that it may not be possible for listeners to initially understand their meaning.

In line with this, some narrative accounts of psychosis suggest that the usual processes of narration are severely compromised in response to unbearable or traumatic experience, and that this results in the person experiencing diminished agency (Holma & Aaltonen, 1997, 1998; Roe & Davidson, 2005). In a way, psychotic experiences take over all the stories and experiences in the person's life, and other voices become silenced or difficult to hear. Along similar lines, psychosis has been described as entailing severe dialogical disruption, which is evidenced in compromised capacity for dialogue between self-positions (Lysaker, Glynn, Wilkniss, & Silverstein, 2010) as well as in a sense-reduced agency (e.g., Lysaker & Leondhardt, 2012; Roe & Davidson, 2005). Individuals with psychosis often describe feeling at the mercy of their symptoms and experience reduced volition, while agency is projected into their symptoms (Lysaker et al., 2010; McCarthy-Jones, Marriott, Knowles, Rowse, & Thompson, 2013); they also describe loss of identity and a sense of dehumanization as they "become an illness," in a process with stigmatizing and self-stigmatizing effects (Dilks, Tasker, & Wren, 2010; Pitt, Kibride, Welford, Nothard, & Morrison, 2009). In addition, the psychiatric discourse itself and the practices associated with it negatively affect the diagnosed person's agency, limiting his or her position repertoire and thus constraining possibilities for self-understanding and action (Avdi, 2005; Harper, 1995; Holma & Aaltonen, 1998; Karatza & Avdi, 2010).

With regard to dialogically informed therapy for psychosis, an important development is Open Dialogue, which was developed in Western Lapland and has shown remarkable outcomes in the treatment of acute psychosis (Seikkula, Alakare, & Aaltonen, 2011). A core aspect of the approach is the generation of dialogue; it is assumed that through dialogue, the family or network's

psychological resources are mobilized, and participants regain their voice and assume positions of increased agency with regard to the symptoms. Dialogue is considered to allow strong emotions to be expressed, new words for difficult experiences to be jointly created, and new understandings to emerge (Aaltonen et al., 1997; Seikkula, 2008; Seikkula, Aaltonen, Alakare, Haarakangas, & Lehtinen, 2006; Seikkula & Arnkil, 2006). In this literature, great importance is placed on the therapists' *dialogical stance*, which is associated with a particular way of listening in a context of acceptance and understanding. The therapists' comprehensive, responsive participation in the present moment discussion is considered crucial for the creation of dialogue (Seikkula, 2011; Seikkula & Trimble, 2005). This leads to a shift in the way the therapist's role is seen, from "doing" some therapeutic intervention, such as interpreting or reframing, to following closely the patient's and the family members' words and utterances and responding to them. This stance relies on a fully unconditional recognition of the embodied experience of the patient; through this, the extreme experiences the patient is talking about begin to seem a more understandable response to stressful situations. In this approach, dialogue itself becomes the aim of therapy, because it is through dialogue that people reach more connections with the various voices of their lives.

In light of the recognition that psychotherapy can play an important role in recovery from psychosis, it is important to examine how therapy is carried out, in order to better understand the processes that underlie it. As has been argued by several authors (e.g., Elliott, 2011; Hill, Thompson, & Williams, 1997; McLeod, 2011), qualitative research—and, in particular, approaches that rely on hermeneutic, narrative, and social constructionist epistemologies—that examines in detail therapy sessions can provide useful insights into the process of therapy. Although generally small-scale, such studies can illuminate in detail how therapy is carried out in clinical practice. Within this framework, it has been argued that different conversational features can be useful and valid markers of both therapy process and, to some extent, therapy outcome (Strong, Busch, & Couture, 2008). This study relies on the detailed analysis, from a dialogical perspective, of sessions from therapy with a couple in which both partners had psychotic experiences. It is exploratory in its scope and aims to examine the potential usefulness of concepts and analytic processes derived from dialogical theory for describing and conceptualizing the process of therapy for psychosis. It also aims to explore those dialogical features that seem to be associated with the emergence of new narratives and new self-positions in the clients' talk. The method followed for analyzing the dialogical features of the sessions is described in the following section.

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EXAMINING DIALOGICAL PROCESSES IN THE THERAPY FOR PSYCHOSIS: A CASE EXAMPLE

The material for this study consisted of three sessions of couples therapy with a heterosexual couple in which both partners had psychotic experiences. The couple had been living together for three years and had recently moved to a new city, where they sought therapy. At the time of the study, Giorgos (38 years) had been hearing harsh and critical voices for over 10 years. He sought therapy in order to better deal with the voices, as he often felt helpless and powerless toward them. Maria (26 years) had a history of psychotropic drug use during adolescence. Since her early 20s she had been hospitalized several times following psychotic crises, during which she experienced persistent and terrifying persecutory thoughts. Maria's main goal in therapy

was for someone to oversee her medication. The therapy took place in a mental health center in Greece, followed several of the principles of Open Dialogue, and consisted of 10 sessions over nine months.[1] There was one female therapist, Danae, a psychologist and group therapist, and one male therapist, Alexis, a psychiatrist and family therapist; both therapists were trained in Open Dialogue. The therapy was considered by the therapists and the couple as fairly successful, although no independent outcome measures were obtained. Giorgos continued to hear voices but described feeling more able to control them and more at peace with himself; Maria continued with antipsychotic medication, which gradually became more acceptable to both partners. The couple started a small business and reported feeling more settled and secure in their shared life. Therapy was terminated when the couple decided to move abroad.

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PROCESS OF ANALYSIS AND METHOD

After obtaining the couple's consent, three sessions from the beginning and middle of therapy were video-recorded (sessions 1, 2 and 6, which took place four months into the therapy) for the purposes of this study. The therapists, who did not participate further in the study, provided the session material. The sessions were translated into English and analyzed using the Dialogical Investigations of Happenings of Change (DIHC). The DIHC has been developed with an aim to capture the dialogical qualities of multiactor conversations, in order to study the processes of meaning construction and interaction in the context of family therapy. The analysis is multifaceted and multilevel and focuses on several interrelated aspects of dialogue. Below, we describe the process of analysis that was carried out on this particular data set; for a fuller description of the method, see Rober, Seikkula, and Laitila (2010) and Seikkula, Laitila, and Rober (2012).

The analysis was carried out collaboratively; the videotapes and session transcripts were initially analyzed by VL and JS, and further analysis was carried out by VL and EA. The videotapes were reviewed throughout the analysis, as they provide important nonverbal information that is not available from written transcripts. Following verbatim transcription, the transcript was segmented into episodes depending on the issue discussed. Next, each topical episode was examined in relation to the following dialogical features: the speakers' relative dominance, the speakers' responsiveness to each other, and whether the language used was primarily factual or symbolic. Dominance is an aspect of dialogue considered important in therapy talk, as it provides an indication of who controls the content and process of the dialogue, and it is defined in terms of three interrelated dimensions. More specifically, *quantitative dominance* is attributed to the participant who speaks more in a specific topical episode; s*emantic dominance* is attributed to the speaker who has the initiative of introducing most new topics or words within each episode, thus influencing most the content of the discussion; and *interactional dominance* is attributed to the participant who influences most the process of the conversation and shapes the interaction, as, for example, when the therapist manages turn taking by inviting someone to talk.

The second dialogical feature studied was *responsiveness,* which is determined by examining sequences of interaction and noting whether the next interlocutor responds to an utterance. An utterance is considered to have been responded to when some aspect of it is included in the next speaker's turn, who displays in this way that he or she has heard what has been said and has taken it into account. Depending on the degree of responsiveness observed, each episode is characterized as primarily monological or dialogical. In *monological* talk, speakers do not

adapt their utterance to the other speakers' talk and speak in a way that actually precludes the others responding; a typical, although not the only, form of monological conversation is that of a question-answer format (Linell, 2009). When a conversation is *dialogical*, on the other hand, it is characterized by reciprocity and responsiveness; each utterance includes an aspect of what has been said previously and is open-ended, thus inviting a response. In dialogical conversations, each issue tends to be discussed for longer and the speakers' roles shift throughout the conversation (Seikkula, 2002).

Finally, the language in each episode was described as either primarily *indicative* (in which words are used to refer to some factually existing object or matter) or primarily *symbolic*. Although both forms of language coexist in dialogue, symbolic language and metaphor are considered important vehicles of emotional expression and meaning making (van Parys & Rober, 2013; Zittoun, 2011).

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FINDINGS

One of the complexities involved in studying multiactor dialogues relates to the need to take into account and examine several people's talk and, often complex, interactions. The three sessions were initially analyzed with regard to each speaker's dominance and responsiveness as well as with regard to the overall linguistic features of the episode. The two therapists had different therapeutic styles, as evidenced in the different patterns of dominance and responsiveness in their talk, so we examined each therapist's talk separately and also examined their combined effects on the interaction. This initial analysis indicated that there was an increase through the sessions in both therapists' responsiveness to the clients' talk and also an increase in the sharing of dominance between the therapists and the couple. Moreover, Giorgos was significantly more engaged and active in the conversations than Maria, who spoke little and primarily only when a direct question was addressed to her. There was little conversation between the partners, and their relationship did not form an important topic of conversation. Based on the above, the topic of Giorgos's voice hearing was selected for further analysis, as it was an issue that occupied a central place in the therapy and reflected the main difficulty he faced. Given that the analysis focused mainly on segments of talk between Giorgos and the therapists, it is best conceptualized as an example of analyzing segments of individual therapy that took place within the context of couple therapy.

For the purposes of this article, we present part of the analysis that concerns shifts in the way Giorgos's difficulties were discussed and in his positioning with regard to the voices. The main dialogical notions used in this more micro-level analysis were voice, positioning, and addressees (Seikkula et al., 2012). *Voice* refers to the speaking consciousness that is rendered visible in an interchange; it can be the voice of someone present or absent, real or fictional, or even the voice of an abstract notion or ideal. *Positioning* refers to the perspective from which the world is perceived (Hermans, 2004). Dialogue consists of different points of view, and any conversation involves the dynamics of identification and differentiation between positions. The notions of position and voice are interrelated, as the speaker, depending on the voices that are present in an utterance, takes up certain positions. The third analytic tool used, the *addressee*, relies on a core premise of dialogism that every utterance is addressed to someone and is shaped by that person's anticipated response. Addressees are not always explicitly stated and may be mainly manifested through

nonverbal means, such as intonation, gesture, or lexical choice, and are thus not always easy to identify.

The shifts observed with regard to the meaning of Giorgos's voices are discussed in relation to the dialogical characteristics of the sessions, and in particular in relation to the therapists' responsiveness. We will use selected extracts from the three sessions to illustrate shifts toward increased dialogicality in the interaction, richer narratives, and indications of increased agency in Giorgos's positioning. It is worth noting that the whole session was analyzed, and the extracts presented were selected as fairly typical episodes of interaction that illustrate the main effects observed through the analysis of the whole session.

Session 1: Giorgos as Weak and Suffering

The following extract from the first session illustrates the first description of Giorgos's problem. The construction and reconstruction of the client's problem is considered a significant aspect of therapy; several discursive studies have shown that an important part of the work of therapy is carried out through transforming the client's complaints into "problems" that can be understood within a psychotherapeutic frame and resolved through therapy (e.g., Buttny, 2004; Davis, 1986). Moreover, talk about problems implicates issues of accountability, responsibility, and morality, so studying problem constructions in therapy also entails examining how speakers position themselves and others vis-à-vis the problem (Avdi, in press).

In the first session, Alexis seems to function as primary therapist, in the sense that he has interactional dominance through most of the session and a significant degree of semantic dominance. In other words, Alexis significantly influences the content of the conversation as well as the interaction, whereas Danae, the female therapist, speaks significantly less and has relatively little conversational dominance. The clients, and primarily Giorgos, have quantitative dominance as well as semantic dominance in many episodes. Furthermore, most of the episodes in the first session (17 out of 21) are monological, and the language used in most episodes is indicative rather than symbolic (in 14 out of 21 episodes).

Throughout the topical episode presented below (episode 5), Alexis (T1) mostly assumes the position of a clinical interviewer, in the sense that he shapes the interaction in a question-answer format; although he seems interested in Giorgos's experiences, his questions mostly orient toward a framework of symptom description. Giorgos offers a vivid description of his experience as well as relevant contextual and relational information, but Alexis does not respond to these rich personal descriptions, so the conversation is considered primarily monological. At the same time, Giorgos describes his experiences mainly within a psychiatric frame and assumes a position of powerlessness and reduced agency toward his symptoms.

A fairly typical interaction of this episode is illustrated in the following extract, which took place early in the first session. Just before this extract, Giorgos describes the emergence of the voices in his life and his understanding regarding their nature, giving a psychological account that centers on his sense of guilt. Alexis does not respond to the issues introduced, interrupts Giorgos's narration, and asks the latter to describe his experience of voice hearing, as shown below.

T1: So that I can understand, now, this is an experience that you've had for how long?

G: Ten years.

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T1: Ten years?

G: It started as delirium, in the beginning it started with some signs. [T1: Mm] I heard, like,

single words, [T1: Mm] single words about things, like "hello," "hi Giorgos" [T1: Mm]

occasionally, approximately once every two months, until in [date] this delirium broke out. [T1:Mm] I had an auditory delirium, the first, like, the first contact I had with this condition was voi- [hesitation], thousands of voices coming from everywhere, from, from the whole neighborhood almost. At that time I lived in [area] [T1: Mm] and then, because at that time I did not accept, generally, let's say, I was somewhat afraid of psychiatry, I was afraid of doctors and so on, [T1: Mm] the solution for me was, I went to my mother and said, "I have this problem, I'm going crazy. I haven't slept for days. I hear voices all the time. I want to go to the countryside, to calm down." And my mother gave me money, and since then, my mother helps me financially ... since I started having this condition. ... (When I moved to the island) within 20 days to a month, like, this problem with the delirium got significantly better, like in three or four days the thousands of voices had become much weaker.

Th1: What I would like to understand is ... you said that you see an image or that you imagine.

G: Yes.

T1: And that this image gradually acquires sound.

G: Yes.

T1: And if I understood correctly, you said it gradually acquires sound and this sound consists of voices.

In talking about his experience of the voices he hears, Giorgos introduces his relationship with his mother, who is described as a supportive presence in his life, and also notes the improvement in his voice hearing when he moved to the island. These issues, however, are not responded to by Alexis, who pursues his own agenda of collecting symptom-related information. It is interesting that Giorgos also shifts to a psychiatric frame, which is arguably more aligned with the therapist's line of questioning. A few minutes later, Giorgos describes his distress and his sense of powerlessness and helplessness toward the voices he hears.

G: I cannot find peace of mind. I cannot find peace of mind. I cannot calm down. I cannot find my equilibrium, when I am with all these voices all the time I. I get very tired trying to have some self-control.

T1: You said you get tired. What tires you?

G: Psychologically, to be able to find my equilibrium, to not hear the voices or, I don't know, to have freedom from the voices. They are, the voices have been on top of me for 10 years now. They, OK, they don't control me, but I often realize that I do things through the voices ... [but] I often cannot move, like, I am so divided that I get to a point sometimes where I don't know whether to move a glass to the sink or not.

This is a typical example of the way Giorgos initially described his experiences of the voices he hears: They are disturbing, restricting, and out of his control; he tries to resist their power and sometimes succeeds, but this takes great effort that leaves him feeling exhausted; often he fails to resist and then he feels divided, helpless, and unable to make decisions or act.

With regard to the broad dialogical features of this topical episode, Alexis has interactional dominance, Giorgos has quantitative dominance, and semantic dominance is shared between them. So, although Giorgos speaks most, the terms of the conversation are primarily set by Alexis, who also often introduces the topics to be discussed. The language used is mainly symbolic, as the conversation is mostly about inner experiences and their meanings. However, Alexis' responsiveness to Giorgos's utterances in this episode—and in the first session as a whole—is limited; Giorgos introduces several ideas and meanings, but Alexis does not include them in his next utterance and, rather, follows his own discursive agenda of collecting information from a psychiatric frame. In this episode, the two speakers function separately, rather than jointly creating shared language. We would argue that this monological interaction does not create opportunities for emotional expression or new understanding. Moreover, it could be argued that it is associated with Giorgos's position of reduced agency (Lowe, 2005; Seikkula, 2008).

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Session 2: Giorgos as a Person Who Fights

The second session is different in terms of its dialogical features, and there is evidence of the conversation becoming more dialogical. More specifically, of the 14 topical episodes that constitute this session, seven are dialogical, wherein the interlocutors are responsive to each other, and symbolic language is used in 10 of the 14 episodes. Moreover, in the episode as a whole, Giorgos has quantitative dominance, Danae has interactional dominance, and semantic dominance is shared between them. In line with the assumption that when semantic dominance is shared, important and emotionally laden issues can be more easily discussed, the effects of the voices on Giorgos's everyday life and his feelings about it are more clearly articulated in this episode. This more dialogical conversation is illustrated in the extract presented below; Giorgos is talking about his psychotic experience (topical episode 7), and the following exchange takes place.

T2: I am asking because I am trying to understand, before and after 28 you were the same person, weren't you?

G: No I wasn't the same.

T2: You weren't the same?

G: I lost many of my abilities. I am very, that is, I feel myself very, I feel that I would be able to do many more things if I didn't have this problem with the voices for the last 10 years. . . . I believe that I would make better decisions, that it would be me who decided, like I said, I went through periods where I didn't know where to leave a packet of tissues.

T2: At points like this you are weakened.

G: I am not just weakened. I felt humiliated. I would say to myself, "This cannot be, you are not able to, you don't have the will power to put the tissues here or there."

T2: The way I am hearing this, Giorgos, makes me imagine you being in a continuous struggle.

G: It is a continuous struggle, every second, every day, all day long. And this thing is terrible, we are, like, making a tremendous effort to overcome it.

In the second session as a whole, therapist responsiveness is higher. As illustrated in the extract above, Danae generally responds to Giorgos's utterances and assumes a position of someone who

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accepts his experiences and tries to empathically understand his perspective. She mostly responds to Giorgos's utterances using symbolic language and often introduces new words; as a result, they gradually jointly construct a new narrative about Giorgos's experiences and sense of self. For example, Danae's response, "The way I am hearing this, Giorgos, makes me imagine you being in a continuous struggle," is a fine example of a dialogical way of responding, rather than giving an interpretation from an outside position. In this utterance she states how she understood Giorgos's utterance, which gives him the freedom to choose if her understanding relates to his experience; this leads him to further elaborate on his experience in his response.

Furthermore, there is a shift in the position Giorgos assumes toward the voices he hears. Initially, he speaks *about* the voices and *to* these voices from a position of suffering, helplessness, and powerlessness. The voices he hears are represented as independent agents that have the power to control his actions, to weaken and humiliate him. A shift begins to take place when the therapist introduces the image of a struggle. Giorgos's sense of loss and personal diminishment is reframed as a fight, and he is positioned as an active agent who resists, a version of himself which Giorgos readily takes up. In this way, a new narrative possibility of self-determination and strength begins to emerge. An important aspect of Danae's responsiveness relates to the way in which she participates in the dialogue at this point; when she introduces the idea of the struggle, she leans forward, her intonation changes, and her voice becomes significantly softer; this is a moment of marked emotional responsiveness on Danae's part.

This brief interchange provides an example of a dialogical conversation, in which the therapists listen to and accept what is being said while also introducing new meanings (Seikkula & Trimble, 2005). In addition to creating space, thus allowing new meanings to emerge, dialogue contributes to mobilizing the couple's resources, and thus new possibilities become available. We would argue that clients' agency increases when they have the opportunity to become agents in the stories they narrate (Seikkula & Olson, 2003).

Session 6: Giorgos in Some Control Over the Voices

The final extract is from an episode toward the end of the sixth session. As before, Danae, the female therapist, has interactional dominance in the episode as a whole, whereas Giorgos has quantitative dominance, and semantic dominance is shared. Moreover, both therapists mostly respond to Giorgos's utterances, the language used is primarily symbolic, and the conversation is primarily dialogical.

G: Basically now, I am making an effort about the guilt I feel. I mean, I try not to feel guilty about anything, because I believe that it is the guilt, like, that causes the voices, the fact that I feel guilty about many things and about anything, anything.

T2: This is an effort you are making on your own?

G: Yes, on the way I think. I, like, say to myself, "They are blaming you. They are blaming you so that you feel guilty, so that you feel bad. So don't feel guilty about anything." That is what I say to myself.

T2: Umm, and "they" are the voices?

G: [Laughs] Yes, "they" are the voices, yes. And in this way, the voices become a little less powerful.

T2: Mm.

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G: I say to them, “You can blame me, but I will not feel guilt. I’ll not feel fear.” That’s the sort of thing I do, and in this way I feel more balanced lately. “You will not turn me into an animal. You will not deaden me. I will have feelings. I will remain human.” That’s the sort of thing I do. On the other hand, like, with the voices I believe, that’s how I see it, perhaps simplifying it a little. I think, “Given that the voices are from Greece, from the island, if you were to leave Greece, how would they li- [hesitation], how would these voices survive?” . . .

T2: After what you said about them surviving, an image came to my mind. Yes, what do they feed off?

T1: What do they feed off?

T2: What do they feed off? It is as if they suck energy from somewhere.

T1: Could it be that they take energy from life itself?

T2: Yes, where do the voices get their energy from?

G: [Laughs] How should I know? I don’t know, I don’t know.

T2: You reminded me of plants, now. If you cut their roots, they wither away, they fall away at some point. But their roots seem to have great strength. You took them to Spain, you brought them back, you took them to the island, brought them here, you fed them medication so that they stopped.

G: Perhaps this is related to the guilt, because they loaded me with so much guilt.

In contrast to the sense of weakness and helplessness evident in the first extract, Giorgos speaks as someone who has at his disposal ways to reduce the voices. He answers back and challenges their power. Moreover, in the session he contributes significantly and directs the course of the conversation. Danae, on her part, does not seem to have a preplanned sequence of questions in mind but, rather, creates space in the present moment by responding to the emotions expressed, thus contributing to a dialogical process. Also, the two therapists engage in a rather playful reflection process, responding dialogically to one another and using symbolic language, which contributes to an increase in dialogue and polyphony.

An important aspect of both therapists’ responsiveness is their use of symbolic language, metaphor, and imagery, which seems to help create dialogical space for strong emotions and for as-yet-undisclosed traumas to be expressed and gradually explored. Symbolic language and metaphor are thought to facilitate the process of emotional expression and narration, particularly in the case of difficult or traumatic experiences, and their presence in therapy talk has been associated with positive outcomes (e.g., Seikkula, 2002; van Parys & Rober, 2013; Zittoun, 2011). In addition to creating space for the expression of intimate feelings, the use of metaphor in therapy reveals the therapist’s readiness to listen to what is being said and to participate—that is, to engage more fully in dialogue.

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DISCUSSION

The analysis in this exploratory study suggests that several dialogical characteristics of the conversations observed over the course of therapy can be used to describe and study the process of therapy from a dialogical perspective. In terms of method, the DIHC proved useful in describing the processes implicated in one example of therapy for psychosis. The method's emphasis on dialogism opens up prospects for a new approach to psychotherapy at both a theoretical and practical level, and is in line with the recent interest in examining therapy in terms of dialogue, narrative, and discourse. It emphasizes meaning construction and interaction, the dialogical nature of the self, as well as the role of dialogical encounters in the therapy process.

More specifically, the analysis illustrates shifts in the dialogical characteristics of the conversation through the sessions and associated shifts in the client's positioning toward increased agency, as well as toward enrichment of the narratives that concern his difficulties. Although it is not possible to ascertain whether any stable developmental change has taken place in Giorgos's experience of his voice hearing and sense of self, the analysis points to a relationship between the broad dialogical characteristics of the conversation (importantly, the level of therapist responsiveness) and the narratives about the problem, the problem construction, as well as Giorgos's sense of agency vis-à-vis his symptoms. The gradual development of more dialogical conversations—evidenced through increased sharing of dominance, increased therapist responsiveness and participation, and increased use of symbolic language—seems to facilitate the joint construction of new words and meanings between the participants, to create opportunities for the expression of strong feelings and for the narration of difficult experiences, and to allow different voices of the client's self to be heard. In this process, new positions become available as Giorgos gradually shifts from a position of weakness and helplessness to a position of someone who fights to overcome his difficulties and who gradually becomes able to control the voices. This observation is in line with the literature that underlines the role of dialogue in therapeutic discussions and in enhancing clients' sense of agency (e.g., Anderson, 2012; Holma & Aaltonen, 1997; Seikkula, 2002; Seikkula & Olson, 2003).

We consider of particular importance in this process the therapists' responsiveness. Drawing on the analysis, the important distinguishing characteristic between the first and the later episodes relates to the way the therapists respond to Giorgos's utterances. More specifically, the therapists' initial position of primarily asking questions shifts to one of mainly listening; this shift entails the therapists relinquishing some aspects of dominance and allowing Giorgos to control the initiatives. Also, through their engaged and responsive position the therapists contribute actively to a new construction of Giorgos's relationship to the voices he hears. Moreover, in the latter sessions the therapists participate on a more personal and emotional level in the dialogue. These findings support the view that a client's sense of agency, which is often impoverished in psychosis, can be reconstructed in the context of dialogue, in which clients have a central place in telling their story. Based on the above, we would argue that detailed analysis of sessions can shed light on the dialogical work that takes place in reconstructing the identified patient's identity, in a manner consistent with the contemporary emphasis on the role of narrative and dialogue in psychosis.

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