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Published in:

Journal of Marital and Family Therapy

DOI:

10.1111/jmft.12457

Publication date:

2021

Document version:

Accepted manuscript

Citation for pulished version (APA):

Dawson, L., Einboden, R., McCloughen, A., & Buus, N. (2021). Beyond polyphony: Open Dialogue in a Women's Shelter in Australia as a possibility for supporting violence-informed practice. *Journal of Marital and Family Therapy*, 47(1), 136-149. <https://doi.org/10.1111/jmft.12457>

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Beyond polyphony: Open Dialogue in a Women's Shelter in Australia as a possibility for supporting violence-informed practice

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/JMFT.12457](https://doi.org/10.1111/JMFT.12457)

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Statement about potential conflicts of interest:

We not aware of any conflicts of interest.

Acknowledgement:

The Centre for Family-Based Mental Health Care are generously supported by The Grant Family Charitable Trust and the Michael Crouch Family Trust.

Article type : Original Article

ABSTRACT

Open Dialogue is a family/social network-centred psychotherapeutic approach to responding to people in crisis and distress. In 2017, Open Dialogue network meetings were implemented in an Australian inner-city shelter for disadvantaged women. The aim of the current study was to explore the experience of participating in these meetings from the perspective of service users and Open Dialogue practitioners. Qualitative interviews were completed with thirteen participants (six service-users and seven practitioners) and analysed thematically. The findings suggested that dialogical processes created safety by attending to multiple voices in non-violent ways that reduced perceived hierarchies. Notions of expertise were renegotiated, which allowed the women to feel heard in significant ways that were different from their previous experiences with other social and healthcare services. Open Dialogue is an approach that can meaningfully attend to some of the power relations within which women live and within which social and health care services are provided.

Beyond Polyphony: Open Dialogue in a Women's Shelter in Australia as a Possibility for Supporting Violence-Informed Practice

Open Dialogue is a family/social network-centred systemic approach to responding to people in crisis and psychosocial distress. It was initially developed in Western Lapland, Finland in the 1980s as a response to people experiencing psychosis. It has origins in systemic family therapy influenced by the integrating principles of the 'need-adapted approach', which was informed by psychodynamic approaches to psychotherapy (Alanen, Lehtinen, Rökköläinen, & Aaltonen, 1991; Seikkula, Alakare, & Aaltonen, 2001). The need-adapted approach incorporated systemic-psychodynamic family therapy and psychotherapeutically-oriented treatment with people experiencing schizophrenia-group psychoses (Alanen, 2009). Open Dialogue is both a way of integrating care and a therapeutic intervention (Freeman, Tribe, Stott, & Pilling, 2019). From an integrated care perspective, social and health care services are seamlessly linked through a series of 'network meetings'

to facilitate immediate help, ensure flexibility in the way care is delivered, maintain responsibility for care and treatment, and provide psychological continuity by engaging a person, their family or wider social networks, and at least two therapists (Seikkula et al., 2006). Network meetings provide a therapeutic forum for understanding problems, making plans and creating dialogue, while situating the client, and differing network perspectives and concerns within a relational and social context (Ong et al., 2019). As a therapeutic intervention, Open Dialogue includes principles around adopting a particular dialogical stance (Olson, Seikkula, & Ziedonis, 2014; Seikkula et al., 2003). Key elements of dialogic practice used by therapists in network meetings include eliciting multiple viewpoints, emphasising the clients' own words and stories (instead of symptoms), listening without a specific agenda, using open-ended questions, valuing transparency, and tolerating uncertainty (Olson et al., 2014).

During its gradual development, Open Dialogue shifted away from conventional Finnish mental health service approaches towards a more collaborative type of therapy that created a need to re-theorise what took place in psychotherapeutic spaces (Haarakangas, Seikkula, Alakare, & Aaltonen, 2007). Integrating the influence of collaborative therapy in practice, Open Dialogue proposes to disrupt power relations in the psychotherapeutic encounter by prioritising collaboration and transparency in decision-making (Seikkula et al., 2006). This approach is used to address feelings of powerlessness that can be experienced when accessing mental health care, and to encourage a sense of agency for service-users by emphasising 'being with' rather than 'doing to' (Freeman et al., 2019). In that it aims to reduce hierarchical relations in the therapeutic encounter and uses a de-pathologizing approach, Open Dialogue aligns philosophically with other violence-informed contemporary family systems therapies founded in a postmodern theoretical perspective, such as those described by Oka and Whiting (Oka & Whiting, 2011).

Open Dialogue has increasingly been theorised from the perspective of 'dialogism', which entails a particular epistemology and a view on human subjects as inherently responsive and un-finalisable (Holquist, 2002). This re-theorising of psychotherapeutic spaces included considering the differences between a 'monological' (totalising) and a 'dialogical' (appreciative) language-use and the notion of 'polyphony'. The developers of Open Dialogue, Seikkula and colleagues, drew heavily on Bakhtin's metaphor of polyphony to describe the particular dialogical emphasis on fostering many co-existing voices within the network without privileging any of them. Bakhtin (1984) used polyphony to describe the relationships between the characters in Dostoevsky's novels. A key aspect of Dostoevsky's

writing for Bakhtin was the dialogic interactions between free, co-existing and un-finalised characters, rather than being bound by a monological author (Bakhtin, 1984). ‘Polyphony’ allowed Seikkula and colleagues to then attend to the multiplicity of outer and inner voices present in a collaborative network meeting, where the therapists would acknowledge all voices, even inner, absent or psychotic voices, describe this process, and consider ‘the relational and dialogic self’ (Holquist, 2002). The aims of polyphony are to reduce the gap between the so-called ‘sick’ and ‘well,’ to create new, shared understandings (Olson et al., 2014). In this way, polyphony holds promise to reduce feelings of powerlessness for service users and disrupt dominant relations of power within the therapeutic encounter.

Researchers suggest that Open Dialogue is a promising approach for people who are experiencing first episode psychosis in terms of improved social and vocational functioning, reduced hospitalisation and emergency psychiatric treatment reduction in residual psychotic symptoms and new cases diagnosed with schizophrenia (Gromer, 2012; Lakeman, 2014). However, there are limitations to consider. Available studies primarily consist of descriptive case studies, qualitative studies and naturalistic designs, with an emphasis on outcomes and effectiveness of Open Dialogue in Western Lapland (Buus et al., 2017). There is a lack of high quality research that considers the perspectives and personal experiences of service users and Open Dialogue therapists (Tribe, Freeman, Livingstone, Stott, & Pilling, 2019). Thus, questions remain about the experience of Open Dialogue in relation to its unique, network-based approach, particular dialogical style of responding, and ambitious aim to reduce feelings of powerlessness in healthcare settings.

Over the last two decades Open Dialogue has been implemented in healthcare services across Scandinavia (Buus et al., 2017), and has been adapted in Australia, the United Kingdom, Italy, Germany, and the United States of America. The approach has gradually been extended to mental health services for people with issues other than psychosis, such as young people in psychiatric crisis (Buus et al., 2019) or young people diagnosed with eating disorders or mood disorders (Sidis et al., 2020). Extending into community services, this study explored the experiences of Open Dialogue network meetings following their implementation in an Australian women’s shelter. The shelter offers safe refuge and crisis intervention for women experiencing compromises to their safety, such as homelessness and violence. We anticipated that Open Dialogue network meetings, which attend to relations of power and privilege, include networks of support, acknowledge all voices in a polyphony (Bellingham et al., 2018), and incorporate a dialogical style might be especially therapeutic for these women. The aims of the network meetings were to improve the network’s

understandings of how women see the challenges they face and to support the network to identify possible resources and ways forward. At no time were any of the women's perpetrators invited into the shelter nor were they included in network meetings.

The World Health Organization (WHO) estimates that one in three women worldwide will experience physical and/or sexual violence by an intimate partner, or sexual violence by a non-partner, during their lives (García-Moreno et al., 2013). Violence against women is a pervasive social problem, and women who use refuges, shelters and crisis centres are more likely to have experienced severe, ongoing and multiple forms of violence when compared to the general population, with 40-84% of these women showing clinical levels of post-traumatic stress disorder (Jonker et al., 2019). Thus, a sense of powerlessness is common to women who use shelters. The experience of violence for women (and people who do not identify within binary gender categories) is disproportionate to men's experiences of violence, and different because it often occurs within the context of intimate relationships within of the privacy of the family home (Ellsberg & Heise, 2005). The difference between men's and women's experiences of violence points to how dominant patriarchal social values, assumptions and gendered norms underpin violence against women (Ellsberg & Heise, 2005). For instance, these values underpin naturalisms regarding women's vulnerability within discourses of biology and exploitation of reproductive labour (Zaretsky, 1976). Violence against women is deeply embedded within our society. It starts early in life, promotes compliance with socially expected behaviours and roles and operates as a mechanism of social ordering (Einboden & Varcoe, 2019). Thus, it is vitally important that responses to women who use shelters demonstrate understanding of and attention to women's experiences of violence and the structures that underpin that violence, and are able to resist social relations that are oppressive or paternalistic.

While the disruption of hierarchies and privilege within Open Dialogue network meetings has primarily been theorised drawing on Bakhtin's dialogism and metaphor of polyphony, this study describes an opportunity to extend this theorisation using a social equity perspective. This perspective supports an appreciation for how power relations operate in privileging certain voices and support or undermine people's rights and abilities to make use of services. We have used this social equity perspective in our interpretation of the Open Dialogue practices in the women's shelter to consider how Open Dialogue aligns with a violence-informed approach.

AIMS OF THE STUDY

Open Dialogue has garnered significant interest around the world and evolved into a social movement for those seeking alternatives to traditional approaches to psychiatric treatment (Buus et al., 2017). Given this interest and potential promise much more robust research of Open Dialogue is required, and in particular, research that explores the participant experience and the experience of those who work dialogically. The aim of this study was to explore the experience of Open Dialogue network meetings at an Australian women's community-based shelter, from the perspective of service users and Open Dialogue practitioners and to explore the particular dialogical style and its aims to reduce feelings of powerlessness in healthcare settings.

METHOD

DESIGN

Qualitative methods were used to explore the experience of participating in Open Dialogue network meetings with the aim to capture rich and nuanced data without giving privilege to any voices. Semi-structured individual interviews were used to explore the experience of introducing network meetings to the shelter from the perspective of women who participated in network meetings and Open Dialogue practitioners, some of whom had extensive training in Open Dialogue and others with introductory training in Open Dialogue. Adopting an interactionist view on interviewing (Holstein & Gubrium, 1995), we regarded interview data to be actively co-created in the interactions between participants and interviewer and that the data needed to be interpreted with an awareness of the situated response structures.

STUDY CONTEXT

The study site was a community-based day-time women's shelter in Australia. Situated in a small house in a metropolitan area, the shelter was open on weekdays from morning to afternoon. The shelter was operated by a private charity with no government funding, relying fully on donations to finance its services. It was staffed by a small team of paid professional employees, including a general manager and two case managers. Over 100 volunteers contributed to the running of the shelter. The service espoused values that included dignity, empowerment, accountability, community engagement and creating safety.

Services provided at the shelter included crisis intervention, ongoing case management, referrals and legal advice. A range of activities and programs were offered,

largely run by the volunteers, with the aim of building the women's confidence, developing their life skills and creating a friendly and supportive place where they could feel safe and relax. Activities included, but were not limited to, yoga, music, creative writing, and sewing, and services included hairdressing, reflexology, and massage. Traditional therapy services were not historically provided by the shelter, however women were typically linked to a multiplicity of public services, some of which may have related to mental health treatment. Women who came to the shelter could have free breakfast and lunch on site, prepared by volunteers, and there were shower and laundry facilities available.

All people who identified as women were welcome at the shelter. The women who accessed the service came from a variety of backgrounds. Often, they were from historically disadvantaged groups and affected by trauma related to homelessness, domestic violence, and mental health and addiction issues. Strict policies were in place that attended to the creation and maintenance of safety for everyone using the space. The environment was organised to provide protection and structured guidance/direction to the women who accessed and worked at the service. To this end, illicit drug use, highly disruptive or violent behaviour and discrimination of any form were not tolerated. Males were not permitted to access the service, and while they were occasionally required to be on site (for example conducting repairs) their presence was actively monitored and kept to a minimum.

OPEN DIALOGUE NETWORK MEETINGS

Open Dialogue therapists collaborated with shelter staff and volunteers who had completed introductory Open Dialogue training, to facilitate network meetings in pairs. All these practitioners received regular Open Dialogue supervision. Service users were encouraged to invite members of their network to meetings, which were scheduled for an hour and a half, and offered every two weeks. The network meetings were characterised by the dialogical approaches of deep, appreciative listening, open-ended and relational/circular questioning and the use of practitioners' reflections in front of the person of concern and the network members.

PARTICIPANTS

All women who attended the shelter and had participated in at least one Open Dialogue network meeting and all the Open Dialogue practitioners who either worked or volunteered at the shelter were invited to participate in the study. Shelter staff provided all eligible participants verbal and written information about the study and notified the

researcher (LD) to establish contact if the person was willing. Some of the eligible women attending the shelter were not invited because of current stress or because they no longer used the shelter. Some of the Open Dialogue practitioners were not invited because they no longer practiced at the shelter and one practitioner declined to participate for personal reasons. We estimated that more than 75% of all eligible participants were recruited to the study.

We recruited and interviewed a sample of 13 participants, six of whom were women who used the shelter, and seven Open Dialogue practitioners. Women using the shelter are described in the study context section above. The practitioners included three paid professional staff of the shelter (two case managers with counselling backgrounds and the general manager who had all completed a 50-hour introductory Open Dialogue training course and received ongoing supervision) and four non-staff members comprising of two mental health nurse academics (Open Dialogue therapists completing 3-year Open Dialogue certification and supervision), a clinical psychologist and a registered nurse (who had both completed the introductory Open Dialogue training course and received ongoing supervision).

PROCEDURE

Participants were individually interviewed by LD, with each interview lasting approximately one hour. LD was not involved in facilitating network meetings at the shelter, but is an experienced family therapist trained in Open Dialogue and a PhD trained qualitative researcher interested in personal recovery from mental illness. Service users and practitioners were interviewed at the shelter or at the researcher's office, depending on the preference of the individual participant. To compensate participants for travel costs associated with an additional trip to the shelter, and a token of respect for their time, service users were given a \$30 grocery store gift voucher at the start of the interview. For the service users, the interviews explored the experience of accessing support at the shelter, the experience of taking part in a network meeting, the potential impact of Open Dialogue, the similarities and differences between this approach and other interactions they have had with care providers. Interview questions also explored what service user participants considered to be potentially helpful or unhelpful regarding this dialogical approach. For example, interview questions included, "What has your experience of network meetings been?" "What have you found helpful or unhelpful about network meetings?" and "How has Open Dialogue been similar or different to other approaches you might have had experience with?" For the Open Dialogue practitioners, interview questions explored the experience of conducting network meetings in

the shelter, what they perceived as helpful or unhelpful about dialogical practices in this context, and the potential impact of working in this way. For example, interview questions included “What has your experience of Open Dialogue been?” “What are the benefits/disadvantages to working like this?” “How has the introduction of network meetings impacted you personally/affected your way of working?” In line with the interactionist stance we adopted, interviews were considered to be co-created and, while an interview guide was used, the interviewer also followed the participants lead. Probing questions by the interviewer were designed to elicit reflective responses from participants and reduce interviewer bias by using participants own words as much as possible. For example, participants might be asked “You described the experience as x, can you tell me more about that?” All interviews were audio-recorded and transcribed verbatim.

ANALYSIS

The aim of the data collection and analysis was to develop comprehensive, rich and contextualised accounts of the experience of participating in Open Dialogue network meetings (Patton, 2015). Data were explored and interpreted thematically with particular attention to the interactional situatedness of data and to ‘complicating and expanding’ the data by continually raising new, more conceptually oriented questions (Coffey & Atkinson, 1996). This meant that each transcript was first coded using a highly open-ended and inductive approach and analysed in-depth, line by line. Second, transcripts were systematically compared and overarching themes and subthemes were gradually identified. Throughout the analysis, memo writing was used as an analytical strategy to develop higher-order concepts while remaining true to the data. To ensure rigor throughout the process of data analysis, coding was initially conducted separately by two authors (LD and RE). RE is also a PhD trained nurse researcher, experienced in critical social methodologies and interested in research related to violence and social justice.

After the first few interviews were transcribed, LD and RE met regularly to compare codes and review similarities and differences in their initial independent readings of the transcripts. Agreements in relation to key ideas from the texts were developed collaboratively. Initially, key ideas made by service users and practitioners were considered separately. However, in the final stage of analysis, as there was considerable overlap between these key ideas in relation to the experience of network meetings, responses were brought together to report the findings in an integrated way. An audit trail was kept ensuring analytic

transparency, which allowed data analysis to be traced from initial coding through to final conceptualisations.

Seikkula's use of Bakhtin's metaphor of polyphony was a good fit in the context of the Finnish psychosis service delivery; however, during the preliminary analyses we noted that all the service user participants emphasised that the key difference for them with the dialogical approach was a heightened sense of safety, compared with their usual communication experiences with care providers. This notion of safety was rooted in the space of the shelter itself, but extended into the dialogical process and interpersonal relations within the network meetings. We read these early service user participant descriptions as potentially referring to a sense of powerlessness or loss of voice that set out a lack of safety within previous mainstream therapeutic encounters. The network meeting was interpreted as a non-violent communicational event that resisted reproducing dominant power relations within the women's social contexts. This interpretation prompted the further analyses of the data to be supported by concepts of equity and power, to provide a lens through which we could make sense of the participants' experiences of network meetings and their potential impacts.

ETHICS

The study was conducted according to the protocol approved by the University of Sydney's Human Research Ethics Committee [2018/1013]. All participants provided informed consent to participate, based on written and oral information about the study. Interview responses were managed confidentiality and all details that could potentially be used to identify individual informants have been altered in the data extracts presented in the findings section below.

RESULTS

Our analyses of the data are organised around a central theme of safety in three different contexts: Safety of place; Safety through the dialogical process; and Dialogue and the wider social context of safety. Overall, data suggested that the existing safety of the shelter allowed the service-users to meaningfully participate in the network meetings. The dialogical process itself, such as use of privileging and eliciting multiple voices and attending to relations of power in the room, resulted in a meaningful experience that reduced hierarchies and created an increased sense of safety for participants. The experience of participating in network meetings was differentiated from other service approaches by both service users and practitioners. One key difference was that Open Dialogue resulted in a non-

pathologising experience, where service users defined their own issues, and felt heard and validated. Dialogical practice was contrasted to the service users' previous experiences of feeling disempowered and unsafe in interactions with social and health care services.

THE SAFTY OF PLACE

Service users identified the shelter as a safe, inclusive and welcoming space describing it as “cosy” (Participants 8, 13), and “warm” (Participants 8, 9, 10), and the staff as “non-judgemental” (Participants 9, 10, 11, 12). One service user (P13) with a history of drug use and domestic instability, who did not use the shelter on a regular basis beyond counselling sessions and network meetings, and had participated in more than 20 network meetings, differentiated between public buildings (such as hospitals and offices), where people can feel “on guard, feel like they need to be on their best behaviour” to the more “homelike” shelter, where people dressed casually and ate together (P13).

The shelter itself is a physically secure building and behaviour in the shelter is guided by clear policies related to equity and anti-discrimination, supporting violence-informed approaches to care. Given the relationship between structural violence and other forms of discrimination, policies and practices within the shelter aimed to respond to the intersectional nature of structural disadvantage for especially marginalised groups, such as women who identify as Aboriginal or transgendered. Attention to issues of racism and transphobia, for example, supported access for a diverse population of women and contributed to ensuring the space was physically, emotionally and culturally safe for all service users.

This sense of safety at the shelter was considered important for the context of practicing dialogical work, and contributed to the women agreeing to participate and engage in network meetings. A service-user (P8) identified as transgender, was subjected to domestic violence, had PTSD, and had participated in more than 3 network meetings. She noted, “[Open Dialogue] was happening at a place I feel safe... if it was somewhere else where I wasn't too sure of [safety]... I'd probably feel a bit sceptical” (P8). Service users differentiated their experiences within the shelter from their experiences within mainstream social and health services. In the context of the safety of the shelter, network meetings facilitated authentic engagement with a population of women that often find it difficult to engage in services.

SAFETY THROUGH THE DIALOGICAL PROCESS

Service users spoke about the impact of the dialogical process itself and all discussed the experience of listening to their own words being echoed back to them as the practitioners

reflected aloud on their thoughts and feelings of what had been shared in the meeting. In-session reflections, a technique where a practitioner put words to their own experience of listening (outer dialogue), were identified as offering new and varying perspectives that allowed service users to clarify their own thoughts (inner dialogue), identify new perspectives, and create new possibilities that increased their own sense of agency. In the context of various ideas being offered, and feelings being expressed, service users made their own decisions about how they responded to the dialogue, which they described as very empowering.

The use of a network with multiple voices in the room, was identified as meaningful by both service users and Open Dialogue practitioners, in that it shifted the traditional expectation that the service user will provide content for the meeting. One service-user (P8), described how shared responsibility for dialogue was different from traditional approaches, “instead of the spotlight being on yourself it’s actually, it’s like a roof lit up ... you don’t feel interrogated”. Accordingly, the inclusion of multiple voices was experienced as minimising relations of power that exist between ‘professionals’ and ‘patients’, with a sense of having a “conversation” instead of being in an interview (P8, >3 network meetings).

Reflections were experienced as authentic, meaningful, and validating. A service user (P12) was subjected to domestic violence, struggled with homelessness and PTSD and had participated in more than 10 meetings, contrasted her experience of a network meeting with prior experiences of having domestic violence minimised by professionals and her network, “when they reflect ... they express how I feel ... even if sometimes I cannot put words to my feelings....it’s a relief that someone understands [this] is ... not just in my mind” (P12).

Engaging multiple perspectives on their issues, allowed the women to feel deeply heard and understood. A service user (P11), a transwoman, who had housing and family problems and had poor mental health and had participated in more than 20 meetings, similarly noted,

“[In the reflection] I heard them say ‘she’ this and ‘she’ that and ‘her’ this ... cause it’s one thing for you to go ‘ok, I accept you for who you are’ and tell me, but to hear them talking about me and accepting me for who I am whilst they’re not talking to me ... that’s much more of a realisation that people are accepting me for who I am.” (P11).

Here, this service user highlights how the reflection offered a sense of acceptance of her identity as a woman, which was consistently a point of contention in social life. Listening in

on reflections between the practitioners, allowed a new level of experience with feeling accepted.

The dialogical process was also seen as a way of flattening an established hierarchy, challenging traditional notions of professional as 'expert', and creating more space for voices of the service-users. For instance, a service user (P13, >20 network meetings) explained how a sense of agency was created,

"it made me think that I could work through things myself [...] Often people have this feeling that if you go into treatment that the health professionals or the counsellors want you to get better on their terms, if that makes sense, which is why it kind of often doesn't work, and people kind of come back to having the problems they were having. Whereas this way, it wasn't like that. I felt I could kind of come to my conclusions on my own terms" (P13).

Having agency within the network meeting extended beyond it, increasing her confidence to manage her problems.

Participants also appreciated being authentic, for example one practitioner working in academia spoke about coming to "these relationships, these conversations, these connections with people and not having to come there necessarily as a 'nurse'... I could just come as [myself]" (P3). Practitioners appreciated the opportunity to be vulnerable and share their own personal and professional stories, insights and reactions. Relatively new to Open Dialogue, one practitioner reflected:

"[This process shifts] the power back into the client and empowering them up to be on the same level because I think in a lot of traditional senses if a client has to see a psychologist, psychiatrist, counsellor.... [well, it's like] you're in a room and you're automatically feeling like 'I'm accessing help', therefore I am 'less-than' and needing an expert or a professional to help me and I'm vulnerable. I still am very, very conscious of that, but it feels after a while and once the rhythm of the session starts that that sort of dissipates a little bit" (P7).

Addressing relations of power is not an automatic aspect of the dialogical process, rather as this practitioner identifies, it is something that requires constant attention and energy. A reciprocal process of learning between the service users and practitioners occurred, aligning with dialogical ideas of 'being with' rather than 'doing to'.

Practitioners also shared that, as a result of working dialogically, they noticed both professional and personal changes within themselves that extended beyond the network meetings. Reflecting on these changes, they considered the impacts of power, hierarchy, and

safety and spoke about being more aware of how they communicate, “respecting otherness” (P4), “being more patient” (P6), and “deeper listening” (P6, P7). A practitioner working in academia, described:

“It’s been a beautiful journey. I’ve appreciated the therapeutical work because I’ve been allowed to share stories that are unbelievable. It’s been very good to sit with people and share these experiences. It always gives me a sense of awe. I feel gratitude towards them that they’ve opened up their lives for me to witness. That witnessing, I think, is slowly changing me.” (P4).

Overall, the dialogical processes, including the use of the multiple voices of the network and the sharing of authentic reflections, created new opportunities for speaking and being heard. The use of a network where polyphony was encouraged and the women’s stories were witnessed included active attempts to ensure service-users set the therapeutic agenda, creating an experience of agency and a sense of safety.

DIALOGUE AND THE WIDER SOCIAL CONTEXT OF SAFETY

Dialogical ways of working were described as something “different” (P1, P2, P4, P5, P7), “special” (P3, P6, P7), and even “spiritual” (P2). The process shifted the traditional focus on professional expertise allowing space to ‘be human’ and vulnerable, and aligned with practitioners’ values and practice ideals. Shared vulnerability meant an increased value on service user’s own ideas and solutions rather than being told what to do by professionals. A service user (P13) described no longer feeling “that there was something wrong with me that needs to be fixed”. Instead, setting the agenda for the network meetings and the absence of “forced resolutions” were perceived as helpful and felt “organic’ and ‘flowing” (P13, >20 network meetings). A service-user (P8) contrasted her experience with Open Dialogue with traditional therapy. She explained that,

“[other approaches are] almost like having a spark and trying to get a fire going and the next minute a bucket of water’s been thrown over it... [Open Dialogue is] ...the spark being lit, the fire just starting to go, and then plenty of air from all sides...It just kept on going and ... then as other people sort of had their views and thoughts and whatever else it just seemed to sort of grow in a way that was more and more comfortable and that’s where I felt that warmth came into it” (P8, >3 network meetings).

The warmth and pace was important, leading to emotional safety during network meetings. Service users spoke about the contrast between Open Dialogue and interpersonal

and systemic barriers within legal, health, and social services, which exacerbated feelings of powerlessness and a lack of voice. One service user (P9) who had experienced intimate partner violence, workplace bullying, and homelessness and had participated in more than 20 meetings reflected,

“[Open Dialogue] gives you that time where you maybe feel heard and ... those experiences I’ve had with hierarchy, like I went through domestic violence and I’ve had experiences with police where I felt like I wasn’t heard. ... I think they just rush you and I think it was important for me to talk about the domestic violence in a place where you just talk about it without being judged or rushed” (P9).

Through facilitated dialogical processes within the shelter, space was created for the voices of these women to be expressed in new ways. The dialogical approach disrupted patterns of communication outside of the shelter, created something new, which all of the service users valued and recommended for other women at the shelter. Service users reflected on feeling surprised that they were able to feel safe and vulnerable while talking freely about their problems. Attention to and acknowledgement of women’s experiences from their perspectives was of central importance.

DISCUSSION

Through exploring the experiences of Open Dialogue network meetings from the perspective of service users and practitioners, we have found that the dialogical process added to the safety created by an Australian women’s shelter. Open Dialogue resisted hierarchies and resulted in a non-pathologising experience where service users defined their own issues and felt heard and validated. These findings suggest that dialogical practices align with a non-violent approach that holds the opportunity to attend to dominant relations of power within which women live, and within which healthcare and social services are provided.

Women who experience multiple forms of marginalisation (e.g. related to race, class, sexuality or ability) experience a convergence of oppressive power relations that underpin brutal acts of violence (Sokoloff & Dupont, 2005; Stockman, Hayashi, & Campbell, 2015). Traditional responses to violence against women tend to focus on direct and obvious forms of physical violence, failing to appreciate the scope of the problem and ignoring the structures that set the conditions for other forms of violence. Structural violence refers to social structures (e.g. economic, political, medical and legal systems) that perpetuate inequity, cause

disproportionately negative impacts and preventable suffering for particular groups and communities.

Attention to structural violence creates opportunity for appreciation of how inequities are created and maintained through various types of marginalisation, including sexism, racism and poverty. For example, prescriptive or normative gender roles can be considered social structures that set the conditions for violence against women (Einboden & Varcoe, 2019). They do this by positioning women in subordinate or even proprietary relations with men, with limited opportunities for decision-making, or access to finances, social networks and mobility. An appreciation for how gender roles are structurally violent requires analysis of the complex social, economic and political ideologies that have positioned women with a lower social status than men. While oppressive gender relations have implications for everyone, the likelihood, severity and experience of violence varies depending on other aspects of social position and privilege.

Although structural violence describes how societal systems, institutions, and ideologies contribute to inequity and other seemingly banal everyday violations (such as social exclusion), a critical social equity lens highlights how structural violence sets the conditions for more overt forms of violence (what we usually understand as violence) (Farmer, 2004; Winter & Leighton, 2001; Žižek, 2009). It also points to the importance of responses from mental health and social services that appreciate and attend to violence, the structures that underpin violence, and resist relations that perpetuate oppressive or paternalistic relations.

Traditional approaches have tended to focus on understanding domestic violence through an individualised, internal, and psychological framework, addressing psychological difficulties created for women by violence that might inhibit a woman's ability to protect herself, as opposed to addressing the wider external, systemic and political factors (Goodman & Epstein, 2008). They also respond to gendered violence in individualistic ways, with a focus on retribution, often leaving the responsibility to women to address their own safety (Einboden & Varcoe, 2019). Thus, these approaches fail to appreciate links between structural and other forms of violence. Goodman and Epstein (2008) argue that psychological experiences might be better understood within socio-political and structural perspectives with attention paid to both therapy and advocacy.

Set within a shelter that was currently helping women with their basic needs for safety, food and shelter, network meetings were able to provide care that was not 'decontextualized' from wider social conditions, as would be usual for traditional health services. This approach

was cognisant of the interconnectedness between structural and interpersonal violence. Within health and social services there is an increasing appreciation for how violence may impact a person's perceptions of interventions and care, supporting a move towards the development of trauma-informed approaches. Browne et al. (2015) argue that to better understand how to create and maintain emotionally safe health care services that are trauma-informed, an emphasis on the intersections of structural and interpersonal violence is needed. They propose that a violence-informed approach offers the opportunity to appreciate how everyday structures that constitute social inequities and marginalisation increase the risk of interpersonal violence (Browne et al., 2015). This orientation resists individualising the experience of trauma, encourages understanding its social complexities, and highlights the need for access to supports for safety. The shelter was already oriented to the provision of emotionally, culturally and physically safe care that was violence-informed. Existing policies and practices demonstrated an understanding of the intersectional nature of violence, including an appreciation for the challenges of transgender women.

Elements of the dialogical therapeutic process itself, in particular the use of polyphony (Bakhtin, 1984), aligned well with the need to acknowledge the context within which the women were living. A key finding of the current study was that the use and privileging of all voices created an environment where the women did not feel interrogated, and where professionals' views or judgements were not prioritised. SAMSHA (2014) describes how specific dialogical processes could be understood as violence-informed. Further, there is a large body of research that suggests that there is healing potential when stories are told in full and that emotional processing, sense making and health benefits can be stymied when survivors are required to tailor stories (Wozniak & Allen, 2012).

Anderson (2005) highlights that when professionals collect a client's narrative with the intention to make sense of it through professional logic and expertise they in fact edit and interpret the client's story, whereas exploring clients' situations dialogically from a not-knowing position, ensures the client's perspective is engaged with and an environment is created in which their concerns are talked about in new ways that lead to new views of themselves. The ability to access necessary assistance by those who have survived violence can also be impeded when they tell their stories of abuse in fragmented ways (Lawless, 2001). Positive relational experiences assist recovery, while negative social interactions can impede it (Kezelman & Stavropoulos, 2018). By attending to and interrupting 'micro-violence', a type of violence that is insidious in interpersonal encounters amidst the inequitable relations of power within social and health care systems, Open Dialogue can be

understood as aligning with and extending violence-informed care. An emphasis on supporting autonomy and agency, and positioning the women as experts within the network meetings, resisted common practices and discourses that position women who experience violence passively or as victims. In contrast, monologue is not only problematic in relation to its totalising language-use, potentially affecting the participants' social identities, but also can be understood as a form of micro-violence and micro-insult, because of the way it operates to silence the participant's voice and interfere with their identity. We viewed monologue as inherent to communication that operates to reinforce dominant relations of power and lacks appreciation of how silencing the other operates to continue to position the participant within the dominant social order, and extend the trauma participant's experience, and erode their sense of self.

Our findings indicate that Open Dialogue network meetings create opportunities for healing potential that are especially useful for people who have experienced trauma and violence. The use of reflections and polyphony invited more sharing, validation, and possible responses. While there have been some suggestions that women accessing shelters might have restricted social networks, this was not an issue for the service users in our study. Similarly, Tucker et al. (2009) found that homeless women's personal networks are larger and more diverse than assumed, and social interventions which create or strengthen the social network have been identified as helpful (Jonker, Sijbrandij, & Wolf, 2012). Due to its ability to create space for women's control over their narrative and to enhance their social position within the relations in the network, polyphony can be understood as a violence-informed approach.

Working together to attenuate hierarchy between the staff and service users during network meetings created safety and suggests that Open Dialogue might create greater possibilities for addressing the needs of women who have been abused. The specific intention to ensure women are positioned as experts, may avoid issues of dependency or enactments of 'victim' and 'rescuer' roles that are more likely to occur within the case management model (Kunkel & Guthrie, 2016). In this context, Open Dialogue network meetings appeared to be helpful to both the service users and practitioners. The dispositioning of experts and an appreciation for the service user as having the most expertise in their own lives not only shifted the social position of the marginalised women, but also allowed the practitioners to work in ways that aligned with their own professional ethics and values, creating an experience that was valued by all.

LIMITATIONS

While a strength of this analysis is the study of Open Dialogue network meetings in a novel psychotherapeutic context, there are some important limitations. A large proportion of, but not all eligible service users and practitioners were participants in the current study. Accordingly, the findings of this paper do not represent all views on Open Dialogue, and it is possible that non-participants' voices would have less affinity towards Open Dialogue and this needs to be systematically addressed in future research.

Data collection ceased once the 13 eligible and willing participants were included, and not on the basis of concurrent analysis and recruitment that could be utilised to indicate a saturation of data. However, the dataset was rich, and we considered both the content and participants' situatedness, which allowed us to confidently develop a small number of themes that were fully saturated by data (all rudimentary themes were omitted from the analysis because they were not sufficiently supported by data).

We found that the collaborative analysis inspired a reflective and 'complicating' (Coffey & Atkinson, 1996) reading process that successfully prevented premature closure of the interpretation of the data set. We believe that this complicating process in tandem with the presentation of richly contextualised data are the key contributors to the analyses' credibility. We make no claims about the transferability of the findings, but invite readers to consider the contextualised findings in a case-by-case manner, cf. (Kvale & Brinkmann, 2014), and the extent to which the findings might have relevance in their own psychotherapeutic contexts.

CONCLUSION

While Open Dialogue approaches have been fast adopted in recent years due, in part, to theorising of how it attends to power and equity issues through the use of polyphonic voices, no research has empirically explored these issues. The metaphor of polyphony has been promoted as a way to explore and understand Open Dialogue network meetings. In this study, dialogical practices have been shown to have beneficial features beyond 'polyphony' alone. The most prominent new ideas were related to the opportunities presented by a dialogical approach to meaningfully respond to women's experience of violence, and – at a more general level – how it is able to disrupt the silencing of voices, and create spaces for socially disadvantaged voices to be heard. Language and the network approach were used in ways that appreciated the violence women experience and the ways in which violence can be reproduced. Findings suggest that network meetings were experienced in a way that illustrates the philosophical intentions of dialogical practice and strengthens dialogical claims that this process, in contrast to other approaches, can enhance the agency and power of the

network members. Findings also suggest that the dialogical process might be appropriate in the context of people who have experienced trauma and violence.

It is possible that other perspectives on dialogical practices, situated in different social contexts, would profit from alternative and supplementing theories that would strengthen therapists' and researchers' 'irreverence' (Cecchin, Lane, & Ray, 1992) towards dominant ideas. By adopting a social equity lens and alternative theory beyond polyphony, we hope to invite future research that applies different lenses through which to examine dialogical processes. Given the recent uptake of the Open Dialogue approach, additional research is needed to better understand the reach of the approach and to add to the growing evidence base (Buus et al., 2017; Freeman et al., 2019). Much more research is also needed to better understand how we can best respond to people who have experienced violence to ensure that all voices can be heard and responded to in ways that create safety.

ACKNOWLEDGEMENT

The Centre for Family-Based Mental Health Care is generously supported by The Grant Family Charitable Trust and the Michael Crouch Family Trust.

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