Postmodern Society and Social Networks: Open and Anticipation Dialogues in Network Meetings

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Network therapy flourished in the U.S. during the 1970s, but has since dwindled there and begun to find new applications in Europe, especially in the Nordic countries. State social and healthcare systems, in developing deep vertical expertise, seems to build up a need for complementary horizontal expertise. The latest theories of sociology are used to analyze the need for networking, with the focus on language and dialogue as specific form. Two

approaches developed in crisis service for psychotic patients (Open Dialogue) and in consultation for stuck cases in social care (Anticipation Dialogues), are dealt with. What becomes essential seems no longer to be the therapeutic method itself but the ability to see the polyphonic nature of clients' reality. In this respect, language–and dialogue as a specific form of being in language–as the focus of treatment, makes the practical forms of different approaches secondary.

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The goal of the present article is to analyze the emergence of dialogism in psychosocial work and discuss its consequences for expertise. The authors also intend to promote integration of psychiatric and social care systems that are based on network therapy and to develop an

integrative view of the nature of dialogues in different settings. The authors come from two traditions: developing a psychiatric crisis intervention system especially for psychotic patients (author JS) and developing network orientation in social care and psychosocial work across the boundaries of multiagency systems (authors TEA and EE). In both contexts, methods based on dialogues appear to be very promising. Applying recent sociological theories in combination with new theories of psychotherapy, the article analyzes developments at the patient/client-professional interface in a wider sociopolitical context. Such developments challenge implementation of first modern or top-down expertise. Dialogism is viewed as mainly professional expertise called for by postmodern[2] development.

Professions performing various types of tasks of psychosocial work, in the private and public sectors, are elements of societal modernization. Tasks of social support and control traditionally covered by communities and personal networks have one after the other been taken over by experts (Hirsch, 1985). He refers to this as socialization of support and control. Specialization has been seen as central to societal modernization (Luhmann, 1989). Systems such as law, economy, science, and politics differentiate and form subsystems. According to Foucault (1977), all professions with the prefix psycho- or socio- (psychologists and psychiatrists, sociologists and social workers, etc.) are based on developing a normalizing gaze

that detects deviations. Normality is the area between extremes. Normalizing power is productive: new objects for study, new knowledge, and new professions emerge, forming a system of professions (Abbott, 1988). According to Bourdieu (1994), newcomer professions try to conquer fields by demonstrating that the controllers of these fields are outdated.

Core development in societal modernization is individualization (Beck, 1992). Traditional bonds (kin, clan, community) tear apart as industrial and postindustrial society emerges. The feasibility of living a more or less detached life is aided by the modern state. Within this process, the normalizing gaze of psychosocial professionals detects obstacles to normal individuation. The attempt to foster healthy individuation in an enmeshed or too loosely knit family can serve as an example. If healthy individuation is threatened, the task of the expert system, e.g., family therapy, is to modify family interaction in order to fulfill its task of producing independent individuals in society.

Paradoxically, the expert system, while refining competent ways of helping people, creates both intended and unintended consequences in problem solving (Giddens, 1979). In the most serious cases of psychosocial help, individuals and families are surrounded by a multitude of experts. Multiproblem families become multiagency families (Imber-Black, 1988). Multiprofessional muddle are late-modern phenomena. Growing awareness of these unintended consequences has led to attempts at finding new ways of helping. These can be defined as a search for second expertise in the second or late phase of societal modernization (Giddens, 1990).

Export and import of network therapies

Although compartmentalization of care was not, at least in Finland, the consequence of a detailed master plan, the sectored mode of producing healthcare and

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[2] Although sociologists call current developments by different names, i.e., Postmodern by Lyotard, 1979; Post-traditional by Habermas, 1984; Reflexive or late-modern by Beck, Giddens, & Lash, 1994; they all seem to agree that something fundamental is occurring, e.g., through globalization, individualization, digitalization, environmental consequences, and full employment crisis. Here the term postmodern has been chosen to represent all these ideas.

other services did not emerge at random. The rationalization of the system world (Habermas, 1984) was, in fact, an intensive phase in modernization, challenged only recently. First, the production of consumer goods, and even later on, healthcare systems, including essential elements of psychosocial work, were turbulent areas of reshaping production along cost-effective lines. Crafted means of healthcare were replaced by large-scale production of health services in huge hospitals with streamlined specialization—creating so-called health factories. Gramsci (1971) called it Fordism. A silo view of planning, management, and production has only recently been challenged by ideas of flexible networking (Castells, 2000). The basic assumption that division into clear-cut portions can safeguard the totality has proven to be a gross simplification in dealing with complexity, such as social, biological, and even technical systems.

In attempts to restructure professional psychosocial help, networking became influential in the therapy world (Trimble, Kliman, Villapiano, & Beckett, 1984). Networks and networking are also catchwords in postmodern society. Network therapy as such was not a postmodern phenomenon, but interesting ways of working with serious crises have been embedded in it. These included in their origins ideas of multiple realities and polyphonic life, which are enhanced through generating dialogue. As they landed in the Old World, they started to change, revealing some interesting postmodern features, especially dialogism as a central element.

Network therapy originated in the U.S. in the mid-1960s, especially through the work of Carolyn Attneave and Ross Speck (Speck & Attneave, 1973), with implications for both social care and adult and child psychiatry. Originally, network therapy meant mobilizing full-scale network meetings around crisis situations (Trimble et al., 1984) and undergoing profound emotional experiences in these meetings. Network therapy flourished during the 1970s when therapists developed a wider repertoire for collaborating in building, supporting, and restoring caring personal communities (Trimble, 1996-1997). It was oriented toward analyzing the structure of the invisible web of ties in which individual and family life are embedded and toward mobilizing networks of people relevant to meetings in crisis situations. Anthropological and other social science literature provided tools and sources of inspiration. After this period, the practice of network therapy began to decrease in the U.S. (Attneave, 1990). One problem was the orientation toward mobilizing full-scale social networks, which could easily involve meetings of 30-50 people.

Economic reasons along with rigid models for organizing social and healthcare hindered the development of network therapy. Some network therapists became critical of the method, particularly concerning the strong emotions generated during and after the meetings (Garrison, 1981). Therapists experienced difficulty in learning to take charge of network meetings. The helpful ideas of system theory in analyzing and mobilizing social networks became available only after the early 1980s, as Attneave (1990) noted, referring especially to the concept of psychosocial network created by Pattison and his team (Pattison & Pattison, 1981). The early network therapists were great enthusiasts with abundant personal charisma that was difficult or impossible for novices to replicate. During the 1980s and 1990s, some family therapists worked with multiprofessional systems (Imber-Black, 1988). Although traditional social network interventions have decreased, the central ideas of network bonds around clients have been used and developed, as

Sluzki (2000) illustrates in his fine analyses of therapy with elderly patients. Many of the language-orientated approaches, such as collaborative language therapy (Anderson, 1997; Anderson & Goolishian, 1988), different forms of narrative (Smith & Nylund, 1997) and solution-focused therapies (deShazer, 1991), also include the nearest social networks in the therapy processes.

Network therapy crossed over to Europe, especially to countries where comprehensive social and healthcare systems already existed (Trimble, 1996-1997). The basic idea that various clusters of people are important factors in a client's life gave an opportunity to integrate the work of different authorities in the same crisis situation. Involved professionals were invited to participate in joint meetings. Professional work began to take place collaboratively instead of each expert working separately with the client according to the principles of his/her profession in his/her consultation room. Multiple resources could be mobilized in tackling the crisis. Such development occurred especially in the Nordic countries, starting with work involving immigrant families and their social problems in the suburbs of Stockholm, Sweden (Klefbeck, Bergerhed, Forsberg, et al., 1988).

In the Nordic countries, a natural presupposition exists for the development of network ideas. The welfare state has, in recent decades, been very active in supporting individualization. In contrast to Southern Europe, where the larger family still has a marked emphasis on social support and control, policies in the Nordic countries have held a relatively independent nuclear family as the normal case. In so doing, they have also produced this family type. Shaping the family was an unintended consequence of a mixture of markets and policies. In Finland, which underwent a severe labor shortage in the 1960s, mothers with small children were recruited into the labor force. A double-income nuclear family emerged. At present, the majority of mothers with small children work full-time outside the home. Along with housing, taxation, and other allowances and policies that support the family, there are professional support systems for children (e.g., daycare, education, etc.), for the elderly (senior citizen care), and for other groups (the disabled, etc.). Lehtonen (1986) argues that the modern double-income nuclear family could not remain functional without societal scaffolding. The family has a multitude of systems, agencies, and professions supporting it, and psychosocial support if needed. Expert systems are replacing many traditional sources of support and control. The Nordic countries are at the cutting edge of the process that Beck (1992) calls the second phase of modernization.

We see three linked causes for the interest toward network therapy in the Nordic countries. First, as the takeover of support and control proceeds, psychosocial expert systems are, in many cases, running out of problem-solving resources. Interestingly, many professionals turn toward clients' personal networks. Second, the psychosocial expert system is getting into complex self-imposed muddles, where compartmentalizing problems to fit streamlined specialization seems to be part of the problem. Finally, the Nordic psychosocial systems are accessible; they are mainly public and free of cost or very affordable.

Expert systems at turning point?

Finnish psychosocial systems must work with all cases, including the most difficult. This increases the professionals' interest in methods that promise ways to get out of complex situations. They seek cooperation over boundaries. Inviting people from the client's personal network to participate in problem solving meant a change in the paradigm where problem

solving was seen as something done by the expert for the individual. The parallel development of societally-aided individuality and specialized expertise created a client-expert dyad expected to be relatively omnipotent. However, additional resources are often called for.

The routine method is to refer the client. In most cases this is unproblematic. Nevertheless, as Imber-Black (1988) points out, there is an inherent trap. If clients are referred with no idea of supportable resources, with the goal of getting rid of the hopeless case, they tend to become seen as multiproblem clients or families. Typically, they will have knocked at almost every door in the professional system. Network approaches have attracted the attention of precisely those professionals who were at the end of the referral chains, with no one to pass the problem on to. Since the public service system cannot be selective, the number of professionals finding themselves stalled or helpless with complex situations is quite high in the Nordic countries.

In our experience, professionals have been more ready to accept the idea of networking among themselves rather than inviting people from the clients' personal networks. The latter course poses a greater challenge to the conventional expertise. However, the urgent need for additional problem-solving resources encourages experts to take the step. When the professionals became brave enough to invite laymen, they were delighted to find new resources for problem solving in crisis situations. This meant, of course, a considerable challenge for the concept of expertise. It was no longer the professional alone who held the keys to solutions. New competencies were required from professionals: instead of prescriptive expertise, mobilization skills were called for. The first modern society produced the sectored service systems and specialized expertise where the expert knew better.

In a network setting, the professional is faced with a great deal of unpredictability. In fact, unforeseen solutions by combinations of people working together are the goal. Top-down expertise begins to give way to networking competencies.

In Beck, Giddens, and Lash's reasoning (1994), high tolerance of uncertainty is central to the postmodern expertise. In the conventional expertise, professionals were expected to have–and perhaps thought they had–a high level of control of consequences. In our view, the postmodern expertise cannot be a characteristic of an isolated professional. Rather, it is embedded in a network of professionals and other stakeholders. In complex, bewildering situations–surrounding multi-problem clients or families for example– expecting ways out through streamlining specialization even further appears far less promising than joining forces, reframing the picture, and tolerating uncertainty.

All of this has also meant changing the traditional idea of network therapy. Handling these types of multiagency quandaries has led us from seeing our position as applying social network intervention ("doing network therapy") to focusing on the language created in the network meetings. It is no longer a question of having a network therapy method, but rather a network-centered approach in most serious psychiatric and social problems. The client's network is not an object for interventions, but rather an irreplaceable resource for proceeding. In the beginning, we were disposed to see network therapy as one method of expertise. At the moment, we are emphasizing the dialogue between the participants in the meeting and, of course, the inner dialogue of each participant. The two approaches described in what follows, open dialogue (OD) and anticipation dialogue (AD), deal with the uncertainty inherent in most serious situations in psychiatry and social

care. Both approaches aim for a dialogue. The pragmatics, however, are different. OD has mostly been applied in severe psychiatric crisis as a form for organizing both the treatment system and the dialogues themselves in the meetings. AD in its origins is a form of consultation in complex processes in social care. Giving a general description of both is an attempt to illustrate how, on the surface, very different types of approaches may include the central elements of postmodern expertise.

OPEN DIALOGUES IN PSYCHOTIC PROBLEMS

The roots of the OD approach lie in Finnish western Lapland, in a small province with 72,000 inhabitants. In the local psychiatric hospital, where one of the authors (JS) worked as a psychologist, family- and network-oriented treatment was the goal. In 1984, the traditional manner of admitting patients was challenged. The team started to organize open meetings, referred to as treatment meetings, to analyze the problem and prepare the treatment plan after a patient was admitted to the ward. The patient participated from the outset. Staff members stopped having their own separate gatherings. At the same time, instead of inviting families into family therapy after the team had defined the problem, the team started to invite families whenever a family member was hospitalized. Gradually, it became evident that this change in working style caused a remarkable shift in the position of the family and the patient. Families were no longer objects for staff-planned treatment; instead they became active participants in joint processes. In many impasse situations encountered in the treatment, the team noticed that the only way forward was to change the team's own activity in the actual situation (Seikkula, Aaltonen, Alakare, et al., 1995). The team began to rethink the

structural paradigm on the principle that it is the team's task to intervene, which in turn effects change in the family (Boscolo & Bertrando, 1993; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978).

Opening doors for families to participate in analyzing the problem, preparing a treatment plan, and participating in treatment meetings throughout the entire treatment sequence were the first steps in seeing all the problems as problems in the actual social situation of the patient. In such situations, many other aspects and other parties in the social network of the patient also proved to be important. In family therapy based on the structural paradigm, the nuclear family is the basic unit, since symptoms are seen as functions of the family system, be it the nuclear family or the extended family (Kemenoff, Jachimczyk, & Fussner, 1999). In the new approach, it became natural to invite all the important participants in the patient's social network in order to increase coping resources and to open up new constructive perspectives.

In building up the family- and network-centered psychiatric system, the next step was to realize the importance of holding the first treatment meetings as soon as possible after the crisis had occurred. This led to a rapid decrease in the need to hospitalize (Keränen, 1992; Seikkula, 1991, 1994). It became necessary to organize a mobile crisis intervention team in each psychiatric outpatient clinic in the province. Currently, all staff members can be called upon to participate in these teams according to the particular need. Regardless of the specific diagnosis, if there is a crisis situation, the same procedure is followed in all cases. If it is a question of possible hospital treatment, the crisis clinic in the hospital will arrange the first meeting, either before the decision to admit for voluntary admissions, or during the first day after admission for involuntary patients. At such a

meeting, a tailor-made team consisting of both outpatient and inpatient staff, is constituted. The team usually consists of 2 or 3 staff members (e.g., a psychiatrist from the crisis clinic, a psychologist from the mental health outpatient clinic for the area where the patient is living, and a nurse from the ward). The team takes charge of the entire treatment sequence, regardless of whether the patient is at home or in the hospital, and irrespective of how long the treatment period is expected to be.

In the treatment meeting, all the important members of the social network, together with the patient, gather to discuss all the issues associated with the actual problem. All management plans and decisions are also made with everyone present. On the whole, the focus is on strengthening the adult sides of the patient instead of regressive behavior (Alanen, 1997). The task of the dialogue is to construct a new language for the difficult experiences of the patient and those nearest him/her—experiences that do not yet have words. In analyzing this OD approach, Gergen & McNamee (2000) noted that this could be seen as transformative dialogue instead of disordering discourse. Although OD is not a diagnosis-specific approach for psychotic problems, treatment of the psychotic crisis best illustrates the central elements. In organizing open meetings, our understanding of the nature of psychosis began to change. In the next sequence, an illustration of psychosis from the social constructionist and dialogical point of view is given.

Open dialogue and psychosis

Psychosis can be seen as one way to deal with experiences so terrifying that they cannot be expressed other than through the language of hallucinations and delusions. For example, most female psychotic patients have experienced physical or sexual abuse either as a child or as an adult (Goodman, Rosenberg, Mueser, & Drake, 1997). In clinical situations, these traumatic experiences are often present in the hallucinations or delusions about which the patients are speaking (Karon, 1999).

Case: Breaking windows

A female patient had been hospitalized for more than 2 weeks, and a treatment meeting was organized to prepare for her discharge. Her husband, son, doctor, ward team, and a two-person team from the psychiatric outpatient clinic participated in this meeting. The patient was asked to describe what happened when she was admitted to the hospital. She answered by describing how one afternoon she was at home with her son who had suddenly asked if there was someone in the garden. She was frightened, believing someone was there, although she could not see anyone. She was convinced it was the man with whom she had been living for a 2-year period, 16 years ago. The following day, when her husband returned home from his work tour and drove into the yard, she started to fear that he was under the influence of drugs and was going to kill her. She locked all the doors so that her husband could not come in. He grew irritated and started to yell while on the front steps. She became terrified and in the end, broke two large living room windows by throwing chairs through them. After this attack she was hospitalized.

The team became interested in her former husband and asked her to tell them about her relationship with him. She said that it was difficult for her to speak about it, never having done so before. The man, she said, was a narcotics addict who, when under the influence, would always assault and beat her heavily. She used to stay home long enough for her bruises to disappear to be sure no one knew she was a victim of her husband's violence. After 2 years she

managed to divorce him. They had not met since. She told that one night, 5 years ago, while she was alone at home, the telephone rang. She answered and found that the man was calling to ask how her life was. She became terrified, began to tremble, and almost ran out of words. After the conversation, she remained terrified for a long time and had her first psychotic break down two months later.

Since this was the first time that she had been verbally able to express these terrifying memories, the team began to ask about concrete descriptions of how the attacks had happened. For example, they asked whether her husband had hit her with his fist or with an open hand. The intention was to have plenty of words available for constructing a story of the traumatic memory. In a stress situation, difficult and terrifying experiences in one's life may be actualized and can be relived (Penn, 1998; van der Kolk, & Fisher, 1995). The person can begin to search for a way to express these experiences in the form of a metaphor. As in the case described, where the patient had a delusion that her husband was under the influence of drugs and was coming to kill her, this was something that was not true at the moment, but had actually happened in a previous relationship.

To have an open dialogue with no preplanned themes or forms for conversations appears to be important in making it possible to construct a new language for describing and reflecting on difficult events. Whatever the background for psychotic speech, it is important in the starting phase of treatment to take it seriously and not in any way challenge the patient's sense of reality during the crisis situation. Instead, the therapist's questions may be as follows: "I do not understand. How could it be possible for you to control the thoughts of other people? I have not experienced that. Could you tell me more about it?" The questions to other network members in the meetings could be as follows: "What do the rest of you think about this? How do you understand what M is saying?" In this way, the task is to afford a variety of voices for the theme under discussion. If the team manages to generate a deliberating type of atmosphere, allowing different, even contradictory voices to be presented, the network makes it possible to construct narratives of restitution or reparation (Stern, Doolan, Stables, et al., 1999). As Trimble (2000) puts it, when comparing the dialogical approach to the ideas of network therapy, "restoration of trust in soothing interpersonal emotional regulation makes it possible to allow others to affect us in dialogical relationships" (p.15). This may be one aspect of the process in which the patient and his/her social network can begin to construct new words for their problems.

In general, the idea for the team during the meeting is to allow the network to take the lead and, by responding to each utterance in a dialogical way, to promote the building of new understanding (Bakhtin, 1984; Voloshinov, 1996). Dialogue becomes both the goal and the specific way of being in language in the therapy. Instead of primarily trying to change the patient (e.g., a rapid removal of the psychotic symptoms), or the family (e.g., a new interactional style within the family system), the main therapeutic efforts occur in the area between the team (and other parties) and the family or social network present. Building up a dialogical rather than a monological dialogue means thinking more about how to answer the utterances produced by the patient and the family. It means being present in the actual conversation. In systemic family therapy, the team employs a tactic, such as circular questioning, through which a change in the family system can be initiated. It is not essential that every utterance be answered, because the primary

focus may be outside the actual theme under discussion.

In OD, the "tactic" is to build up dialogical discourse. In the dialogue, new understanding starts to emerge as a social, shared phenomenon. The individuals present at the meeting are speaking about their most difficult experiences. In the dialogue, the goal is to capture the behavior of the patients as one dimension of their life context, which often means that even very odd types of behavior start to seem more normal. One element of this normalizing discourse is that those aspects of the patients' hallucinations or delusions that are mixed in with the real incidents in their lives are highlighted. The difficult reality can be shared, and thus new resources become available. What first occurs in outer dialogue in the social domain may thereafter evaporate into an inner dialogue. Vygotsky speaks of the zone of proximal development (Vygotsky, 1978) in the child. This idea can be used to describe the psychotherapeutic situation as well (Leiman & Stiles, 2001). This may be one explanation as to why psychotic patients frequently are able to participate in the conversation in the first meetings without psychotic experiences (Alanen, 1997).

One way to respond is to have reflective conversation[3] (Andersen, 1995) among the team members—by the very same professionals who are conducting the interview. No specific reflective team is formed, but the team members change positions in a flexible way, from con-

structing questions and comments to having reflective conversation with other team members. Sometimes this presupposes that the team asks permission to do so: "I wonder if you could wait a moment so that we could discuss among ourselves what we are beginning to think. I wish that you would sit quietly, and listen if you want to. Afterwards, we will ask for your comments on our discussion." Usually, the family and the other part of the social network listen very carefully to what the professionals say about their problems. Reflective discussion has a specific task. Since the main idea is to construct treatment plans in these conversations, everything is transparent. Decisions concerning hospitalizations, motivation for medication, and use of individual psychotherapy are examples of the content. Discussions are aimed at opening up a variety of alternatives for decisions. In the case of a decision for involuntary treatment, for instance, it seems to be important that different opinions and even disagreement over the decision can be openly expressed and discussed.

Guiding principles in Open Dialogues

Several studies have provided information on the course and results of treatment (Keränen, 1992; Seikkula, 1991, 1994). There are also qualitative analyses of dialogues in treatment meetings (Haarakangas, 1997; Holma, 1999). The results are promising. The incidence of schizophrenia, according to DSM-III-R, has decreased, since 1985 through 1994, from 33 to 7/100,000 inhabitants (Aaltonen, Seikkula, Alakare, et al., 1997). In an ongoing study of first-episode psychotic patients, the need for hospitalization decreased and the use of neuroleptic medication could be compensated for by using anxiolytics at the outset, so that 26% of the 80 patients used neuroleptics during the two-year followup period (Alakare, 1999; Seikkula, Alakare, Aal-

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[3] Reflective conversation means making it possible to shift between outer (talking) and inner (listening) dialogues. Andersen created a reflective team in which, at one point in the family interview, the interviewer, together with the family, could start to listen to the team member's reflection about what they had heard during the interview. After this, the family had an opportunity to give their comments if they wished.

tonen, 1999, 2000). This did not lead to poorer outcomes: 83% of the patients had returned to their jobs or studies, or were job-seeking, and 77% did not have residual psychotic symptoms. One reason for quite good prognoses was suggested to be the fact that the duration of untreated psychosis was only 3.6 months in Western Lapland, where the network-centered system had enabled easy contacts to psychiatric care and an immediate start of treatment (Seikkula, Alakare, & Aaltonen, 2001). In many other studies, the duration of untreated psychosis has been noted to vary approximately between 12 months (Loebel, Lieberman, Alvir, et al., 1992) and 3 years (Larsen, Johannessen, & Opjordsmoen, 1998).

As an outcome of research programs and psychotherapy training, seven main principles of OD have been established.

1. Immediate help. The units arrange the first meeting within 24 hours of the first contact, made by the patient, a relative, or a referral agency. In addition, a 24-hour crisis service is set up.
2. Social-network perspective. The patients, their families, and other key members of their social network are always invited to the first meetings to mobilize support for the patient and family. The other key members may be other authorities, including employment agencies and health insurance agencies in support of vocational rehabilitation, colleagues or the head of the patient's workplace, neighbors, or friends.
3. Flexibility and mobility. These are guaranteed by adapting the treatment response to the specific and changing needs of each case, using therapeutic methods that best suit the case. The treatment meetings are organized at the patient's home, given the approval of the family.
4. Responsibility. Whoever received the

first contact is responsible for organizing the first meeting, in which the treatment decision is made. The team takes charge of the entire treatment.
5. Psychological continuity. The team takes responsibility for the treatment for as long as needed in both the outpatient and inpatient settings.
6. Tolerance of uncertainty. Tolerance is strengthened by building up a safe enough relationship for the joint process. In psychotic crises, the development of an adequate sense of security requires meeting every day for at least the first 10 to 12 days. Premature conclusions and hasty treatment decisions are avoided.
7. Dialogism. The focus is primarily on promoting dialogue, and secondarily, on promoting change in the patient or family.

ANTICIPATION DIALOGUES

Anticipation Dialogues (AD) consists of a set of methods that have been developed in successive research and development projects throughout the 1990s, organized by Stakes (National Research and Development Center for Welfare and Health, Finland) in collaboration with several Finnish cities (Arnkil, 1991a, b, 1992; Arnkil & Eriksson, 1994, 1995, 1996; Arnkil, Eriksson, & Arnkil, 2000). The general goal of these projects has been to develop resource-centered methods, a network-oriented work approach, and service structures that transcend sector boundaries. The goal was to develop psychosocial child and family services, especially in multiproblem situations and in preventive work involving social and health services and other networking actors. An effort was made to improve the quality of the work performed with clients by developing dialogic methods that showed consideration for the clients and their personal networks and work practices that supported their resources.

Although ODs and ADs are close relatives and are both network-oriented and dialogic, their working procedures are very different. Two ways of engaging in AD are presented in the following section: recalling the good future and multiprofessional anticipation dialogue. The methods are very structured; an independent consultant takes the lead for outer dialogue that occurs in the form of talks that should not be interrupted.

Case: Recalling the good future

A social worker, worried about the situation of a young child in a family, summoned a network meeting with the consent of the parents. The parents decided not to bring the child, but both brought their mothers. Also present were the various professionals (about 10 in all) who were involved in helping and controlling the family and who had been invited with the parents' consent. The gathering brought together the stakeholders who had been working separately for years, doing their best, but increasingly worried about the child's situation and also dissatisfied with what the others had been doing.

Authors TEA and EE were invited to facilitate the dialogue. They explained the idea that speaking and listening are separated to allow rich inner dialogues and that the facilitators interview the family members and professionals about a good future. They went on to explain that this is done in order to bring to the fore points critical for a plan of joint action to make a good future come true. In other words, the platform is for negotiating clarity and coordination, not for decision-making. The facilitators arranged the larger family (parents plus grandmothers) around one table and the professionals around a second one. One facilitator joined the family; the other joined the professionals. The extended family group was interviewed first.

The first facilitator asked the parents and grandparents, each in turn, to think aloud: "Let's assume a year has passed. Matters are well in the family now; the child's situation is better. How are things now, from your point of view?" "What are you particularly happy about?" The facilitator assisted the families in taking off into the future by asking about concrete everyday matters. Every now and then the facilitator quoted in a summarizing manner what had just been said, carefully adhering to the words used by the family. He inquired, "Have I heard you correctly, in that you said. . .?" This was to help those involved to reflect by echoing what they had said in the course of thinking aloud and to underline that the intent, in the session, was to listen keenly to everyone.

After hearing each family member's views on the good future, they were asked, still supposing a year had passed: "What did you do to make this good development possible, and who helped you, and how?" Through this question the activity and support network was outlined.

The third round, at the family table, was facilitated by the question: "What were you worried about a year ago, and what lessened your worries?" In this way, present worries can be approached from a less stressful future viewpoint. The process of voicing reflections was aided by the facilitator's summarizing quotations, and by his inquiries on whether or not the family members' views had been correctly heard. The family's views of the good near future now became the fixing points for a constructive plan of action. The basic elements of the good situation were written down for all to see. The family members were asked to correct the notes if needed.

The second facilitator began to interview the professionals. One after another they were asked two questions while the others, including the family, listened to the questions: "As you heard, things are

going well in the family now that a year has passed. What did you do to support these good developments?" "What were you worried about a year ago, and what lessened your worries?" The process of the professionals voicing their reflections was also aided by short quotations. After this round, the professionals′ views on helpful measures were written down (and corrected if they so wished). A discussion followed on whether or not all present could commit themselves to the emerging plan. Agreements on the next steps and followup sessions were then made. The session ended with the participants deciding who would coordinate further actions.

Isomorphic interactions

Immediate feedback from such dialogues has been very positive, for both clients and professionals. Family members report that they find it a relief to imagine a less burdensome future in the presence of professionals who normally focus on problems and shortcomings. In the sessions described above, all the participants gather impressions at the same time—and know that all others hear what they are hearing. This appears to be quite an intervention in itself. It is more usual for the counterparts in a multiagency network to meet the clients separately, guessing what the others are doing. It is not unusual for the interaction in the professional network to replicate fundamental figurations in the personal networks. On the one hand, (Arnkil & Eriksson, 1995) professionals' activities mirrors clients' activities for positive reasons: professionals identify themselves emotionally with their clients and are thus able to understand them more comprehensively than by mere cognitive means. On the other hand, through such empathizing, professional work is constantly at risk of becoming more of the same, i.e., professionals may replicate among themselves–and with the client–the fundamental fig-

urations in the families and in the personal networks. It is not exceptional that in split situations, the professional network becomes divided, or that systems of blame or secrecy prevail among and within agencies. Client and helper figurations may become isomorphic (Schwartzman & Kneifel, 1985). This seldom promotes change. It is precisely in and for such stuck and worry-laden situations that the Anticipation Dialogues were originally developed.

In the above example, the method of Recalling the Future was applied. This seems to be the most powerful method in the set of ADs. As can be seen, the facilitators (network consultants) take the lead in turn and organize the external dialogue as a sequence of uninterrupted speeches. The facilitators move the monological thought experiments along with their questions and help them to develop into dialogues. It is essential that the facilitators do not attempt to solve the case and that they refrain from giving advice (even if they are tempted to do so and, in our experience, often are). They must stick to facilitating the process of dialogue. This is the most valuable contribution that they can make to the involved network.

Merging sources

The basic sources of inspiration for the method are clearly visible. Like Andersen (1990) and his team, AD facilitators separate speaking and listening to create room for rich dialogues. Like Seikkula (1991), we too organize network meetings of involved stakeholders. And, as deShazer (1991) does, we approach present problems from future solutions. We have found it necessary, however, to also ask directly about the worries. If present worries are not addressed in the joint dialogues, they seem to reappear in backtalk, outside the dialogues, and may dominate the view. To enhance commitment, it is

necessary to encourage credible hope. The first question (assuming that things are well after the year has passed) carries certain euphoric elements. The third question (what were you worried about a year ago?) is, in a way, a realizing question, but offers an opportunity to handle today's problems from the perspective of possible solutions. The AD set of methods, and Recalling the Future as one of them, have been developed in and for situations that are susceptible as isomorphic developments. The facilitator's active role is in curbing cycles of blame, domination, etc., by (a) helping to construct the family's good future (instead of presenting demands for change) as the fixing point of plans, (b) promoting polyphony by conducting an external dialogue through interview while comment is restrained (instead of allowing dominance of defining and watertight views with no openings for change), and (c) encouraging subjectivity by interviewing each participant concerning personal viewpoints (instead of allowing others to attempt to dictate how family members should think or act). The goal of ADs is to help stakeholders find coordination in a network that they cannot control either directly or unilaterally. The basis for coordination is sought in the lifeworld of the clients instead of the professionals' specialized tasks.

You can change only your own activity

In our projects, we initially started with multiprofessional meetings—without clients present. If a professional found him/herself constantly worried about a child (or, in elderly care, a senior citizen) and found that the professional network was not making progress, i.e., was unable to proceed or was in great disagreement, even if everyone was doing their best to carry out their responsibilities, she/he summoned the involved professionals for a clarifying session. We (TEA & EE) were called in to act as facilitators. We orga-

nized a multiprofessional anticipation dialogue, suggested that speaking and listening be separated, and asked three questions of each participant while the others listened: (a) What would happen if you did nothing (in the given case)?, (b) What could you do (to help)?, and (c) What would happen if you did that? The professionals were thus encouraged to focus on themselves, instead of the clients, and on intended and unintended consequences of their actions instead of objective problem definitions. In fact, no problem definitions were made. This shift in gaze was intended to promote curiosity; curiosity in turn endeavored to encourage experimentation. Experimentation was intended to pave ways out of impasse situations in which counterparts usually expect others to change.

No overall descriptions or full-scale plans were made. At the end of the sessions, a simple agreement was made on who would do what with whom next. Typically, a large proportion of the network would decide that they would step back and follow up. The participants seemed surprised and relieved to realize that the only factor they could directly change was their own activity, in which, at long last, they had a realistic target for change. The shift from attempts to change clients, families, and neighboring agencies was marked. Work regained an experimental nature, multiproblem situations became interesting, and there was room for new influences.

It appears that abstaining from defining a common problem promotes multiprofessional collaboration. That there is no objective picture of a situation and that each observer has his/her perspective in the observing system became very clear in the sessions described above. Commonly occurring joint problem definitions are, in our experience, not only futile, but hinder collaboration. As Anderson, Goolishian, & Winderman (1986) point out, problem definitions tend to capture participants into

problem talk and reproduce problem-determined systems. Moreover, there are no common problems to be defined. The shift in focusing from defining underlying problems to anticipating possible consequences of one's actions seems, in our experience, to keep professional duels at bay. Furthermore, if problems are seen as problems of activity and not as characteristics or qualities of a person, family, professional, agency, or the like, it becomes very clear that each player has his/her own activity problem. In an interesting way, asking involved specialists to anticipate makes them equals. No one can say with certainty what will happen if this or that or nothing is done. Increasing subjectivity to the extent that one realizes that objectivity comprises an endless polyphony of subjectivities appears to pave the way to the postmodern expertise with fewer fantasies of control and a high tolerance of uncertainty—and curiosity toward others′ subjectivity. In our experience, professionals listen with great interest to each other's anticipations and seem to appreciate the expert professional knowledge and contextual wisdom ("knowing from within" the relationship, as Shotter [1993] calls it), that each specialist can bring to bear.

Anticipating the consequences of noninterventions aroused the professionals' curiosity toward the clients' personal networks. Would someone else help if the professionals did nothing? Again and again the professionals were surprised how little they knew about these potential resources and became curious about them. The step toward inviting personal networks was no longer a giant leap.

Guiding principles in Anticipation Dialogues

Apart from the future recalling and multiprofessional anticipation methods, the AD set includes variations designed to suit planning tasks of preventive work.

We will not discuss them here. They are, in short, methods for working out joint themes, organization, and tasks through dialogues, and they greatly resemble the methods described above (for a detailed account, see Arnkil, Eriksson, & Arnkil, 2000).

It seems that the sectored and specialized professional system is desperately in need of intermediaries. ADs are usually one-time consultations, the main purpose of which is to clarify complex situations and promote change by producing inner dialogues as much as possible with everyone present. Experiences in these consultations have been good. Feedback from both clients and professionals has been very positive. Their experience is that clarity and hope have clearly increased during these sessions even in very complicated situations.

Based on development work, feedback, and training experiences, eight main principles of AD have been established.

1. Subjectivity. Each participant is encouraged to elaborate his/her own point of view instead of trying to represent the overall picture. Already, the settings emphasize that the overall picture comprises a multitude of subjective pictures. Gaining more understanding of others' points of view and positions can lead to a better understanding of the interactive and interpreting network in which one is embedded. A transition from objective problems to subjective concerns is central.

2. Emphasis on the reciprocal character of professional work. In the conventional expertise it was acceptable for the expert to say (reproducing a top-down setting): "You have this or that problem." The expression "I am worried about this or that and my possibility to help" suggests, in principle, a professional's request for help from the

clients and their personal networks. They are potential providers of problem-solving resources (whereas they tended to be potential sources of disturbance or problem-sustainment in the conventional expertise).

3. Polyphony. The principle of subjectivity is tightly linked with the principle of polyphony. As Castells (2000) points out, networks have no centers because each link or participant is the center of his/her network, and subjectivity is a way to make sense of multisubjective systems. Networks are also fundamentally uncontrollable—too complex for unilateral control.

4. High tolerance of uncertainty. Because networks are fundamentally uncontrollable, a high tolerance for uncertainty is called for. Polyphony in dialogue enhances tolerance of uncertainty.

5. Dialogism. Dialogues can provide enriching impressions of the multisubjective systems in which one is embedded and understanding not available for detached actors.

6. Experiments in thought and action. Subjective anticipation brings to light the fundamentally experimental nature of all activity. Confident predictions belong to conventional expertise whereas postmodern expertise is based on tentative anticipations and sensitivity to the fact that actions have both intended and unintended consequences.

7. Future perspective as the basis for coordination. Very little emphasis is put on the past. Instead, the future of the life-world of the clients serves as the platform for coordinating activity.

8. Facilitation. The Fordist system of professional help creates a great need for facilitation. Facilitating both horizontally (e.g., between professions, over sector boundaries) and vertically (e.g., between managers and personnel, professionals, clients, and personal networks) puts into action the seven preceding principles.

DISCUSSION

Both approaches are dialogic and network-oriented. On the surface, they are almost opposites. ADs are very structured, not open. The facilitator–the network consultant–conducts the dialogues. Strikingly, ADs are unsuited for those crisis situations in which ODs function best. ODs appear to be helpful in psychotic situations where ADs do not appear advisable. Conversely, ADs yield the best results in open-care muddles, which are not the basic territory of ODs. The authors of this article became curious about the complementarity of the approaches. Do they, through contrast and comparison, reveal something essential about the contexts in which they are applied?

One would expect that severely split or psychotic situations, for which ODs are well suited, would call for methods more structured than lighter cases and vice versa. Curiously, the less-structured ODs are an intervention suited to highly structured care contexts, e.g., mental hospitals. ADs, on the other hand, are at home in outpatient care, where the professions of various agencies meet each other as well as common clients in a diffuse no-man's land. The cases dealt with in the open care of child welfare are by no means lighter than the psychotic cases encountered in adult psychiatry. The big difference is in how the treatment filters through the professional system. In adult psychiatry, the serious cases should, in principle, be dealt with in highly specialized–and institutionalized–units right from the beginning. In Finnish child protection, the ultimate responsibility is in the open-care system—and with child welfare social workers. In adult psychiatry, one encounters strongly structured modes of service; in child protection, one encounters institutional vagueness.

ODs and ADs share common ground in dialogism, polyphony, and social constructionism. The authors of this article are intrigued by the possibility that they are approaching something post-Fordist from different angles and in different contexts. What becomes essential seems no longer to be the intervention itself or the therapeutic method itself. Rather, what is essential is seeing the polyphonic nature of our clients' reality. In this respect language–aiming for a dialogical conversation in both approaches as a specific form of being in language–as the focus of treatment makes the practical forms of different approaches secondary. We can make use of ODs, especially in the heaviest crisis situations and of ADs in impasse cases encountered in social care, while making use of our understanding that the resources for recovery are in the dialogue itself.

The basis for attempts to help professionally is formed by listening carefully to what the client, members of the family, and those of the personal networks have to say about the good future, in the case of ADs, and in finding expressions for terrifying experiences in the ODs. The expert system is reminded that the basis for help is in the comprehensive life-world, not in the specialized fragments as seen in the system-world. Already, the setting emphasizes that the top-down approach of the conventional expertise must be turned around. Specialized expertise, however, does not become obsolete. It can be made a more fruitful element of the whole if the fixing point is the life-world instead of one's professional slice. At least in the Nordic countries, the second phase of modernization appears to challenge the top-down expertise carried out by singular professionals.

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