19 Therapeutic Politics and the Performance of Reparation: A Dialogical Approach to Mental Health Care in the UK

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A young woman is sitting on a chair, arms crossed in front of her, her back facing a room full of people she has never met before and who know nothing of her life. Beside her sits her father, and on the other side, her mother. Facing them, towards the audience of mental health professionals in training, sit a psychiatrist and a mental health nurse, their chairs turned to form a circle enclosing this intimate yet very public dialogue. The young woman, Anne, starts to speak, nervously, laughing quietly as she remarks on the way she has positioned herself to sit with her back towards all these strangers. She pauses and then continues, the psychiatrist and nurse looking at her warmly and listening, nodding regularly in agreement and encouragement, and the family talk among themselves following Anne's lead for the best part of half an hour before the nurse offers any response. We hear about Anne's struggles while she still went to school, the tensions in her family, her attempts to make sense of what was happening in her life, and her eventual diagnosis of bipolar disorder during a brief but distressing stay in the acute psychiatric ward of a hospital. Her parents' interjections as she speaks – remarking about their feelings when Anne hit certain lows, and communicating their support for her but also their fears, their desires for her life, and their ideas about what might make things better for her – are offered with their voices louder and more confident than that of Anne, but sometimes they waver, pausing as they gather themselves when on the verge of tears.

The nurse starts to speak only when Anne talks of their first encounter, around fifteen months before today's meeting, when they had started to work together in the therapeutic practice of "Open Dialogue" that they are now engaged in demonstrating for this audience of training practitioners. They smile at each other, mutually reflecting on what they describe as the "journey" they had been on to reach the point that Anne is considering moving away from her parents and going back to education. Having started from the aftermath of her detention and forced treatment under the UK's Mental Health Act, and

her parents' shock and feelings of helplessness in the face of her emotions and behaviours, they describe some of the difficulties and processes of transformation they had each faced. Anne talks about her pleasure in discovering that she could form relationships of trust with the nurse and the psychiatrist, having previously experienced mental health care professionals as complicit in her suffering – not listening to her but rather imposing on her both their understandings of her problems and medication that she didn't want to take. The psychiatrist smiles listening to this, reflecting on how she, too, had experienced their relationship as a revelation – that gaining Anne's trust through their conversations had changed the way she thinks about how she interacts with all her patients. She also describes how in her own life she had experienced challenges as a mother, trying to balance the urge to protect her child with the need to let them make their own decisions and choices, and she shares how she had felt an emotional connection with Anne's parents in light of this shared life experience. The five of them continue to talk in this way – between poignant reflections, gentle humour, and moments of delicacy and sadness – for around another forty minutes as those gathered around the circle listen and watch, seemingly absorbed in the ebbs and flows of this conversation.

The conversation – dialogue, in the terms of its participants – took place as part of a training program in which mental health practitioners in the UK were learning the language and techniques of a therapeutic approach called Peer-Supported Open Dialogue. The audience to the dialogue of Anne, her family, and the practitioners working with her, were among the several hundred mental health care professionals from across the UK, who since 2014 have been undertaking such training programs. In these programs, trainees are encouraged to question the premise and use of their clinical expertise, to challenge hierarchical relationships among mental health professionals, as well as between professionals and service users, and to fundamentally reorient their approach to psychological distress by undermining their own sense of certainty about what it is to experience mental ill health. Psychiatrists, psychologists, nurses, social workers, occupational therapists, peer support workers, and others, have all been among those to embark on what they often refer to as their "journey," training and starting to practise, in this approach. Central to Peer-Supported Open Dialogue, or "POD," are the practitioners' endeavours to learn a different kind of therapeutic language, in which the words of service users and their family and friends are placed at the centre of therapeutic sessions through a particular set of linguistic and embodied techniques. As a way of trying to avoid the deficiencies of mental health care typical in "treatment as usual," in POD, several practitioners will meet with a service user and members of their "social network" (this can refer to anyone the service user wants to bring to a session, but generally – in discussion and in practice – means members of their family) in the midst of crisis. In this meeting, practitioners will attempt to create

an encounter in which diagnostic categories and questions about medication are secondary to a focus on the words and feelings of the service user, their family members and friends, and indeed also on the affective responses of the practitioners. The approach seeks to avoid, as far as possible, the potential violence of involuntary hospital admissions and coercive treatment that are otherwise so common in service users' trajectories through mental health care services.

I followed the attempts of mental health practitioners to reorient their professional lives in this way over a two-year period, doing ethnographic research at training sessions, public events, and in staff meetings and supervisions. Learning the language of POD requires an intensive and often personally challenging process of *un*learning of clinical expertise and identity, as many practitioners describe it, with training programs using techniques such as mindfulness meditation, group role-play sessions, and explorations of trainees' own family and social histories, in order to lead practitioners to experience forms of relationality and vulnerability that are to be the basis of their new style of working with service users. These programs rely heavily on the performance of the approach in "live" dialogues, sometimes with networks appearing as guests in the training program and making themselves vulnerable by entering into a dialogue in front of an audience of trainees, as Anne and her family did. Or these live dialogues feature participants in the program themselves experimenting with the genre as they reflect in front of the rest of the group about their personal and professional experiences, and often about their experience of the training program and the process of re-education they are going through. This dialogue format was rarely absent from any POD event, whether a clinical session, a team meeting, a training program, or public-facing events such as the POD annual conference: a performance of affects and embodied responses among speakers and listeners is central to how POD attempts to have both healing and persuasive effect.

The dialogue as a performative act, voiced by participants seated on chairs in a circle facing each other, is a key embodied and linguistic form in which anyone who becomes involved in POD is required to become fluent – the way in which one introduces oneself (first names, no titles, often with a personal anecdote or detail about one's life), how to use body language to indicate one's willingness to listen and be open to others (leaning forward, arms open), what kind of words to choose (talking about how you feel listening to the words of another person rather than talking about what you interpret of their situation). As such, these dialogues require a kind of public vulnerability, an exposure of the self and an affective relationality that is felt to be unfamiliar in these kinds of therapeutic and professional spaces. There are often emotional moments, and personal revelations that feel weighty. With speakers often referencing a past state of affairs, a more coercive or damaging one, they require

an empathetic response that creates a new kind of relationship among the participants. These encounters are thus transformative of the people involved, and work to create the sense of a broader social project of which they are all a part. The regular and repeated performance of these dialogues takes on the form of a ritualized language and space through which people become emotionally and professionally invested in Peer-Supported Open Dialogue, and which signals the coming into being of a movement pushing for systemic reform in mental health care services.

In this chapter I reflect on how the set of embodied linguistic practices that form the basis of this therapeutic space are informed by political ideals of collective repair in the face of systemic suffering, and professionals' complicity with that suffering. In tune with other chapters in this section, I suggest that this particular manifestation of therapeutic speech, and its ideas of liberation from suffering, reflect the political paradigms and debates of its time. In this case, the practices of speaking, listening, and response at play, and their capacities to do or undo harm, to be more or less free from harmful social practices, have much in common with what has been described as the "rupture-repair-redemption paradigm" (Drabinski 2013) of moves to promote reconciliation in post-conflict settings. In a similar vein to Michael Lempert's tracing of the cultivation of "receptive co-presence" thought to be required for the right kind of listening in postwar American liberal democracy (this volume), and Summerson Carr's study of American psychotherapies as dynamic sites manifesting political questions and free speech ideals (this volume), here I consider the form of truth-telling engendered in POD as a manifestation of an embodied mode of reckoning with past harms requiring a form of performed public vulnerability through words spoken and received. These modes of publicity and vulnerable testimony recall those that have become emblematic of a global reparative politics.

The specific ways in which mental health practitioners and service users are invited to publicly stage a recalibration of their relationships, and its potential to repair harms done, are akin, I submit, to how perpetrator-victim relationships are framed in the forms of reparation considered to be possible through practices of public testimony and witnessing. As I will elaborate in what follows, the ways in which POD imagines power relationships to be manifested and potentially changed through specific speech and listening practices reflects how therapeutic speech practices are imagined here not only as addressing the subjective or interpersonal domain, but as themselves having political effects. I will argue, in this vein, that not only has politics taken on the language of the therapeutic, as is commonly suggested (and mostly in the sense that this is to the detriment of collective political struggles), but that therapeutic speech practices work with and on bodies and subjectivities that are presupposed as the basis of reparative politics. Thus, to consider the idea of social and political

repair in the wake of harm done, we need to attend not only to the truth-telling speech that is thought to expose wrongdoing, but to the ways those who speak and hear it are invited to be in relation with one another in and through these speech practices.

Crucially, in POD, the performed public dialogues often involve both a reckoning with the past and a performance of an alternative social and therapeutic orientation in the present. Those who have experienced mental health services first hand often speak of the harm done to them through the failings of the system of care as it has existed in the wake of deinstitutionalization and the rise of biomedical, rather than psycho-social, approaches to psychological distress, as well as in the undermining of even those services under austerity politics and its stripping back of mental health care services over the past decade in the UK (F. Wright 2022). Narratives of suffering under a broken, neglectful system, as well as in the face of cruel encounters with individual professionals working within it, are often prominent in how people frame their experiences of psychological suffering and any forms of healing they have experienced. Understandings of the harms people have suffered while under the care of the UK's state mental health services are discursively linked to a view of those services as themselves being in crisis, a condition that is linked with the ways in which coercive treatment and detention in psychiatric wards can be experienced as violent and retraumatizing. POD is often then introduced as a form of redress, sometimes even redemption, when these experiences of suffering can be bracketed as in the past, or at least as in the process of being worked through.[1] Through the approach a new language and embodiment of relational, vulnerable selves – mutually implicated in distress and enabled to address it – emerge in the present as performed in the dialogue.

This ritualized mode of therapeutic speech carries strong echoes of similarly collective and performative forms of testimony and truth-telling in post-conflict and settler colonial settings, where truth and reconciliation commissions (TRCs) have often been at the forefront of movements for justice and reparation. Partaking in a globalized genre of witnessing, in what John Borneman (2002) described as a form of "cultivated listening" that is made essential to the kind of truth-telling emerging in these modes of speech, POD's dialogues

1 POD as it is being introduced in the UK is a particular version and development of Open Dialogue – a therapeutic method developed in Finland's Western Lapland region since the 1980s – and follows its core principles and practices (Seikkula 2011; Seikkula and Arnkil 2006, 2014). Two key adjustments to POD in the UK context have been (1) the involvement of peer support workers, practitioners who are explicitly recognized as having "lived experience" of mental health difficulties and services themselves, and who use this experience in their therapeutic encounters with other service users; and (2) the practice of mindfulness by POD practitioners (Razzaque 2015, 2018).

share with the politics of TRCs the premise that a social and political transformation will be brought about through these ritualized speech performances. In POD gatherings, participants often spoke about their practice with reference to political movements, one trainer referring to the need to challenge suffering within mental health care as the "last great struggle" in the civil rights movement. Another spoke about POD's dialogical methods as being not just about psychological distress but as connected to a democratic deficit evidenced in political events such as the Brexit vote and Donald Trump's election as US president, suggesting that the modes of listening and responding practised in POD could be the basis of a revitalized polity as well as having individual therapeutic effects. Central to the link I am drawing between this global politics of reparative speech and POD's dialogical therapy, and to the link POD practitioners themselves drew between their therapeutic speech and notions of being implicated in a wider social nexus, is the notion of an accountability made public, the performativity of words that, by being spoken in a particular way before an audience, invoke specific interpersonal and thus political effects. For the truths told in this genre involve risk in the exposure of participants' past and present vulnerability, their capacity to be injured by the forms of care and coercion described but also, in the case of the mental health practitioners involved, their modes of complicity with these practices and the transformation they undergo in acknowledging and addressing their own positions within this system.

As in Drabinski's (2013) analysis of the politics of reconciliation, in this case too, the close study of the "kinesics of truth-telling speech" – the gestures, the words, the tone of the telling – reveals that the embodied performances of telling these truths, and of reforming selves and relationships, are critical in these moments' ritual efficacy. Consider the following scene, in which forms of speech and listening constitute a ritualized inversion of a normalized hierarchy between practitioner and service user, considered as effective in the reconfiguration of power relationships within the therapeutic practice. In front of a room crowded with practitioners training in POD, two women sit on chairs, elevated on a stage, one empty chair between them. Jenny – a woman whose experiences of being subject to mental health care services, including sometimes coercive treatment that she brings to her work as a peer support worker in a POD team – is interviewed by Rachael, a psychologist. Their conversation lasts the best part of an hour before they take questions from those in the room. Narrating what she describes as her "journey" through several psychological crises, family breakdowns and moments of abandonment, and her attempts to enter and re-enter paid work, Jenny talks at length and with ease in a manner that she is clearly accustomed to. Rachael does not need to ask much, only offering brief responses, voicing empathy and sharing the feelings evoked for her by listening to Jenny's narrative. Details of Jenny's time spent

in an acute psychiatric ward, "pacing the halls," being put on and taken off various psychotropic medications with each subsequent admission and change in doctor, form the backbone of her account. A social worker who looks beyond medication to help her with her benefits and housing, and a psychiatrist who takes a critical view of the long list of diagnoses and treatments she has endured and takes her off all of her medications, offering his time and sitting with her unmedicated self simply in order to listen, appear as key figures whose presence prefigure the therapeutic relations to which the POD trainees in the room are invited to aspire. After a short pause, a moment of silence, Rachael asks, "Can I just reflect?" Jenny nods and Rachael, pointing to the unoccupied chair in between them, becomes tearful and says, "Just thinking about the voices not in the room … I just feel really sad sitting here."

Rachael's invoking the "voices not in the room" and linking her emotional state to their absence connected the dialogue between her and Jenny to the more standard circular format of POD and its staging of particular relational forms. For while there had been a back and forth between Jenny and Rachael, parts of their conversation felt much more "monological," in POD's terms, in that Jenny spoke at length, uninterrupted, as an "expert by experience," using the time given to her to speak in front of this audience to inform them of her experiences. It was clear that it was not the first time she had given an account of herself in that way, and that she had become one of those people whose suffering in relation to mental health services was regularly mobilized to invite a certain kind of self-reflection on the part of its practitioners – someone whose "lived experience" was considered the basis of a privileged form of truth-telling thought to have the capacity to shake up long-standing inequalities in whose voice is heard and legitimized in relation to psychological distress. Where "monological" modes of speaking (those that involved the practitioner speaking from a privileged position of expertise, by, for example, the clinician giving advice, talking about treatment plans, or initiating new subjects the network members have not brought up) were discouraged during the POD training program, here it served a rhetorical purpose, inverting how power relations were understood in the POD community to place the service user in the position of monological authority in relation to the practitioners.[2] The "voices not in the room" imagined by Rachael were those other service users who had not been able to speak publicly of their distress as Jenny had, and perhaps their family members, even those occupying the position that Rachael did of the therapist whose role it is to facilitate the voicing of suffering. In calling forth those absent voices, Rachael brings the relationships among people occupying

2 For ethnographies of the monologic, and a discussion of the relationship between monological and dialogical speech, see Tomlinson and Millie (2017).

these various positions into the conversation, inviting the audience of practitioners to relate to Jenny's story as a part of the dialogical mode of communication in which they are being trained. She invokes a wider community in which relationships of responsibility and complicity are to be renegotiated through certain linguistic formulations and the delivery of them in particular embodied ways.

This wider community is one bound through the expression of affect, as is reflected in the way Rachael chokes on her words above, tears forming as she is moved by the relations she makes part of her conversation with Jenny. Showing one's vulnerability and exposing one's emotional responses were core aspects of dialogical communication taught to the practitioners undertaking the POD training. As well as staged dialogues between people like Jenny and Rachael, as described above, practitioners, in particular, were thought to need particular training in both feeling and expressing their emotions. The training program assigned considerable space for reflection and public speech of a kind imagined to allow affects to seep through an otherwise detached persona who has been professionalized not to show their own vulnerability. For example, in the "fishbowl" slots, often timetabled at the end of a day or week of the training program, those attending the program would sit in a large circle around a small inner circle or four of five chairs, where there was a microphone ready to be passed on to the next person who would come to occupy one of the central chairs in order to share some feeling or reflection on their experience in the training in front of the whole group. These were often moments of intense collective feeling, in which those picking up the microphone would give voice both to a confessional practice (speaking of the harm they feel they have been party to in the past) and to their own emotional response to this reckoning.

For example, Benjamin, a clinical psychologist, spoke during one fishbowl about how during the training he had come to recognize that he had been "dead to [his] own feelings" in his professional practice, and after the training felt that he had been given a way to bring his emotions and vulnerabilities into his work that would help to create a therapeutic relationship with service users. Another trainee, social worker Amanda, broke down in tears as she spoke about the discomfort she had felt for many years in relation to things she witnessed, as well as in her own practice, at work, and that with the mode of being in dialogical relation with service users enabled by POD, she would finally be able to practise "with integrity." These forms of communication that particularly encouraged practitioners to publicly speak of their implication in the doing of harm, and a commitment to a different future practice, served to underline the structural designs of these speech practices, in that through embodying and performing a vulnerable self, the directionality of the psychological and affective impact of the therapeutic practice is destabilized. This redirection of harm through public, truth-telling speech, is considered in POD to be central

in remaking a dialogical community of speakers and listeners whose shared vulnerability facilitates psychological repair.[3]

These speech practices – the words participants are invited to speak, and the affective and embodied expressions and practices that are considered necessary to deliver and to listen to them – bear strong resemblance to those of TRCs. Ronald Niezen (2016, 925–6, 930) describes how Canada's TRC on Indian residential schools affirmed the "survivor" as its dominant category of victimhood through specific forms of giving testimony. Much like the scenes described above, people were invited to sit in chairs in a circle, with audiences around them listening, while former students narrated histories of traumatic events of abuse and humiliation, so much so that those without such traumatic experiences were reluctant to take up the microphone. As Niezen argues, such practices do much more than simply provide a space in which certain truths can be told. Rather, they shape what forms of truth will be recognized as such, through inviting certain categories of person ("survivor" and "perpetrator") to perform an affective and embodied form of speaking and listening considered as authentic in that context. These forms become exemplars as forms of truth telling that can both uncover hidden histories and provide a form of healing (Shaw 2007).

The politicized ideal of reparative speech as it is manifested in these kind of spaces, as well as in POD, then, involves an elaborate set of practices around the words spoken, which produces a certain framing of ethical and affective relations among its speakers and listeners. The intended result is a recalibration of those relationships based on the ritualized telling of painful histories. As Borneman (2002, 289; emphasis in original) suggests, witnessing here "involves the listening and speaking of at least two parties, and its intended end is *truth-telling* … giving voice to individuals who have been silenced, but here I want instead to concentrate on witnessing as an act of listening, on the relation of speaking to the listener, a third party after a violent conflict." As Lempert (in this volume) similarly argues, listening "is not passive but interactive, involving soliciting, questioning, and weighing competing accounts, as well as hearing. Listening can be learned and cultivated, and some individuals are far better at it than others. I am suggesting here that we rethink the very practice of listening – both what should be listened for, and who might be the best practitioners of listening after violent events" (Borneman 2002, 293). Similar to POD's emphasis on listening as central to effective dialogue, Borneman's (2002) interest in finding better forms of listening itself echoes a broader cultural investment in listening as ethical and political practice, in which the idea

3 For a more extended discussion on understandings of the relationship between speech, harm, and affect in late liberalism see F. Wright (forthcoming).

that how one positions oneself as listener will affect what kind of redress can be done in light of harms done, and one's complicity with them. In POD, the rotation of trainees from the position of speaker, giving voice to one's role in sometimes harmful practices, to that of listener, the witness to fellow practitioners' similarly confessional accounts, works to create a community of truth-tellers who are such only insofar as they also hear and hold each other accountable. Thus here, too, listening comes to hold an ethical and political quality as a crucial element in the dialogical form that is held up as the grounds of reparative speech practices.

Scholars of TRCs in the arena of global politics have analyzed how the therapeutic logic of speech events in post-conflict settings or in the aftermath of founding historical violence works to create the effect of a scene of reparation: as if something previously whole had been broken by violence, and is repaired in the ritual moment – when justice is done – and wholes are once again made. The "rupture-repair-redemption" paradigm (Drabinski 2013) works on the premise that it is the act of truth-telling through the exposure and transformation of vulnerable, injured subjects that can repair a broken community and move a collective towards justice and democratic futures. As Richard Wilson (2001, 98) notes, TRCs and human rights hearings in post-conflict settings were "emotionally intense public ceremonies which generated collective moral values and sought to inculcate them in all who participated." The moral and political force of this embodied and affective relationship to truth and repair are also connected to its pitfalls – the ways in which it sidelines enduring structural violence and may prioritize certain forms of performed, public victimhood which eclipse people's ongoing struggles. If it is the "triumph of the therapeutic" (Torpey 2001) in these domains of political transformation after violence that is often analyzed as a problematic feature of TRCs, what of the translation back into the therapeutic domain of this politicization of healing speech? For, in Peer-Supported Open Dialogue, the voice of the therapeutic encounter is charged with a moral and political force, seeming to borrow from the ways in which politics has been spoken in the language of healing.

In one way of understanding such practices, TRCs are seen to be indicative of an increasingly dominant mode of politics in which psychological and bodily states come to the fore, at the cost of thinking about systems, structures, and histories. In this analysis, we lose out on the collective ability to effect systemic change, because of the limiting of the field of political struggle to the inter-subjective, therapeutic realm. There is another way in which we might view these embodied performances, though, and here it is important to think about how these dialogues have travelled – from the scene of therapy, to the domain of politics and justice, and back again. In the retranslation back into the domain of injured and healing selves and relationships, the practice of performing vulnerability and the exposure to risk involved in truth-telling

has lent words and gestures a different quality, a political force. The healing promise of the therapeutic space also becomes a mode of addressing the harms done beyond the personal relationships being voiced between the people sitting in the circle of a dialogue. So it is not only, as Drabinski (2013, 119) argues about the politics of reconciliation, that "we have to live with, and sometimes as, this body who is performing and gesturing such sadness. All of this violence haunts us yet at the same time promises to transform our possibilities as a polity." Rather, or also, this polity is invoked and transformed in the reconfigurations of embodied selves and relationships that are performed in the dialogical approach to psychological harm and distress that I have described in this chapter. POD's performed vulnerability can be understood as a ritualized mode of therapeutic speech that partakes in a global politics of testimony and witnessing, in which what is remade, or repaired, is the very idea of political community, and not only the psychological states of its members. In this sense injuries and vulnerability become part and parcel of what is considered as the healing capacity of truth-telling speech – reparation as a process of speaking the truth of violence done, and embodying the broken foundation on which relationships can be transformed.

As scholars have noted, this modality of truth-telling speech – that of authentic testimony and confession – both has a grounding in Christian discourses on suffering, forgiveness, and redemption (Derrida's "Globalatinization" [Drabinski 2013, 120]) and is merged with a notion of reconciliation that is vague enough that it can appeal to different groups of people with various agendas (R. Wilson 2001, 101–10). Thus, its uptake and transformation in POD can be married with an eclectic array of founding texts and approaches to the therapeutics (in POD these include Bakhtin's thought on dialogism, theories and practices from systemic family therapy, and Buddhist meditation). In common, however, these political forms presuppose the possibility of repair based on the exposure of the truths of rupture through words spoken and heard, a paradigm mirrored in therapeutic forms that view their work as the repair of community and polity, as well as intersubjective healing. Speaking and listening in the truth-telling forms of Peer-Supported Open Dialogue is thus as much the enactment of an imaginary of reparative citizenship, as it is a therapeutic mode seeking to facilitate repair within and between those who perform its language of vulnerable testimony.