

# OPEN DIALOGUE

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# WESTERN MASSACHUSETTS CONNECTICUT RIVER



QuickTime<sup>®</sup> and a  
decompressor  
are needed to see this picture.

# Open Dialogue at Keropudas Hospital in Tornio, Finland

É Developed and first evaluated by the hospital team led by Jaakko Seikkula, Ph.D., Birgitta Alakare, M.D, and Jukka Aaltonen, M.D.

É Inspired by the work of Yrjö Alanen, M.D. in Turku:  
• Need-Adapted Approach.

ó Treatment Meeting and Rapid Early Intervention

# Finnish Open Dialogue

- É Congruent with existing empirical knowledge of psychosis derived from basic research.
- É Integrates different approaches, though mainly rooted in systems thinking.
- É Consistent with recovery principles and practices and related US system-of-care initiatives of contemporary mental health policy initiatives.

# KEY ASSUMPTIONS OF OPEN DIALOGUE

- É Neither the patient nor the family are seen as either the cause of the psychosis or object of treatment but competent, or potentially competent partners in the recovery process.
- É Psychosis is a temporary, radical, and terrifying alienation from shared communicative practices: a ðno-manøŕ landö where a person has no voice and no genuine agency.

# EMERGENCE OF OPEN DIALOGUE

É Failure of traditional family therapy models at Keropudas.

É Beginning in 1984, the "Treatment Meeting" evolved into main therapeutic forum

- ó meshes a form of psychotherapy with a way of organizing and delivering integrated treatment in the community.
- ó Focuses on reducing the patient's isolation by generating dialogue--and thus, a shared language--and by preserving their social network.

Clinical-theoretical influences include  
psychoanalytic and systemic :

É Andersen's reflecting process (Andersen, 1987;  
1991)

É Goolishian & Anderson's collaborative  
language systems approach (Anderson &  
Goolishian, 1988)

É Bakhtin's idea of dialogism (Bakhtin, 1984)

# Open Dialogue: 2 Levels of Analysis

## A. INSTITUTIONAL PRACTICES (MICROPOLITICS)

Treatment Meeting

Training: Rigorous 3-Year Training Program

## B. LANGUAGE PRACTICES IN THE FACE-TO- FACE ENCOUNTER

Tolerance of Uncertainty

Dialogue (Dialogism/Dialogicality)

Multiplicity of Voices (Polyphony)

## 7 MAIN PRINCIPLES FOR OPEN DIALOGUE IN THE TREATMENT MEETING

É IMMEDIATE HELP

É SOCIAL NETWORK PERSPECTIVE

É FLEXIBILITY AND MOBILITY

É RESPONSIBILITY

É PSYCHOLOGICAL CONTINUITY

É TOLERANCE OF UNCERTAINTY

É DIALOGISM (& POLYPHONY)

# IMMEDIATE HELP

É The team arranges the first meeting within 24 hours of the initial contact, made either by the patient, a relative, or a referral.

# SOCIAL NETWORK PERSPECTIVE

- É The patient, the family, and other key members of the social network are always invited to the first meeting to mobilize support for the patient and preserve this network around the patient during the crisis.
- É All professionals are included.
- É Everyone meets together in the same room.
- É The crisis induces a therapeutic team that responds to the acute phase and becomes the permanent team for the treatment.

# FLEXIBILITY AND MOBILITY

- É The time and place of the meeting is flexible.
- É The treatment is adapted to the changing needs of the patient.
- É Different therapeutic approaches are recommended in addition to OD depending on the needs of the case: e.g., individual psychotherapy, traditional family therapy, art therapy, occupational therapy, and other kinds of rehabilitation services. Medication is used on a case specific and selective basis.

# RESPONSIBILITY

- É ●●● The professional first contacted by the family or referring person assumes responsibility for organizing the first meeting.
- É The team takes changes of the treatment process.

# PSYCHOLOGICAL CONTINUITY

- É The team takes responsibility for long-term continuity of clinical care both in the inpatient and outpatient settings.
- É The same team operates both in the hospital and in the outpatient setting.
- É In the next crisis, the core of the same team is reconstituted.
- É People are not referred to another place.

# TOLERANCE OF UNCERTAINTY

- É Creating safety is accomplished by meeting intensively with the patient and network until the crisis is resolved. In a psychotic crisis, this may mean meeting every day for 10-12 days.
- É Daily meetings and careful listening and responsiveness to the concerns of each person help to foster a safe atmosphere.
- É The result is that uncertainty can be endured and premature conclusions and treatment decisions avoided.

# DIALOGISM (POLYPHONY)

- É Establishing a communicative relationship with the person at the center of concern.
- É Rapport with the person leads to their greater empowerment
- É A common understanding of the situation within the network.
- É All treatment issues are discussed openly while everyone is present, including hospitalization and use of medication.

# DIALOGUE

“For the word (and, consequently, for a human being) there is nothing more terrible than a lack of response”

“Being heard as such is already a dialogic relation”

-- Bakhtin, Speech Genres. P. 127

# MECHANISM OF ACTION

## É INDUCES A TEAM EARLY ON-

- ó An integrated treatment with inclusion of natural supports

## É SELECTIVE USE OF MEDICATION

- ó Congruent with studies suggesting that case-specific use may improve care

# RESEARCH

É Outcome Studies since 1988

É Finnish National Integrated Treatment of  
Acute Psychosis Multi-Center Project

É Need for Rigorous Replication

Five-Year Outcomes for First-Episode Psychotic Crises in  
Western Lapland Treated with Open Dialogue  
Diagnosed with Schizophrenia (N=30) and Other Psychotic  
Disorders (N=45)

Antipsychotic Use	Never Exposed:	67%
	Used During Study Period:	33%
	Ongoing at Five Years:	20%
Psychotic Symptoms	No Relapses During Study Period:	67%
	Asymptomatic at Five Years:	79%
Functional Outcomes	Working or in school:	73%
	Looking for a job:	7%
	Disability:	20%

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