CHAPTER 14

Open Dialogue: An Approach to Psychotherapeutic Treatment of Psychosis in Northern Finland

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Open dialogue is a social constructionist approach to treating severe mental illness that was developed at Keropudas Hospital in Finland, where it continues to evolve and expand. It is more a way of thinking and working in psychiatric contexts than a defined method. In this chapter, we describe this approach to treatment, focusing on treatment meetings as the primary forum for generating dialogue. We first outline the project's history and identify seven guidelines for organizing treatment. We then detail the pragmatic and theoretical foundations for treatment meetings, which are the heart of the open dialogue approach.

Background

The treatment area of Länsi-Pohja, situated in Western Lapland and bordering Sweden to the west, serves a population of 68,500, which is linguistically, ethnically, and religiously homogenous. Located in Tornio, Keropudas Hospital houses the sole psychiatric treatment facility in the area and accommodates fifty-five patients, including thirty acute cases. Although the total land area of Länsi-Pohja is 7,000 square kilometers, 80% of the population is concentrated in two major cities: Tornio and Kemi.

The population distribution is problematic as reflected in Western Lapland's unemployment rate which is over 15% compared to 8% nationally. The rapid move away from an agrarian economy to a more centralized city-based service economy has significantly impacted the population in terms of mental health. The incidence of schizophrenia had been extremely high before the mid-1980s, with an annual average of thirty-five new schizophrenia patients per 100,000. The mid-1990s saw a rapid decline in that number to 7 per 100,000 owing to the development of the new family- and network-centered treatment systems, namely, the need-adapted and open dialogue approaches (Aaltonen et al., 1997).

From the Need-Adapted Approach to Open Dialogue. Psychiatric treatment of schizophrenia in Finland began to evolve in the early 1980s with the work of the Finnish National Schizophrenia Project and the introduction of the Need Adapted Approach (Alanen, Lehtinen, Räkköläinen, and Aaltonen, 1991). The Need Adapted Approach emphasized (a) rapid early intervention; (b) treatment planning to meet the changing and case-specific needs of each patient and family; (c) attention to the psychotherapeutic attitude in both assessment and treatment; (d) viewing treatment as a continuous process, thus integrating different therapeutic methods; and (f) consistent monitoring of treatment process and outcomes (Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991; Alanen, 1997).

The Need-Adapted Approach developed further in the 1980s into open dialogue by the psychiatric unit of Finnish Western Lapland (Länsi-Pohja). This model of intervention organizes psychotherapeutic treatment in treatment units consisting of mobile crisis teams, patients, and their social networks. By the mid-1990s, this kind of psychotherapeutic treatment was available for all patients within their particular social support systems. Currently, all five mental health outpatient clinics, together with the Keropudas Hospital, use case-specific mobile crisis intervention teams. All staff members (both inpatient and outpatient) can be required to participate in these teams; therefore, all are offered an opportunity to participate in either a 3-year family therapy or similar program. From 1989 to 2003, 94 professionals have participated in the family therapy program and have thus qualified to practice psychotherapy under Finnish law, increasing the number of psychotherapists per capita in this area to the highest in Finland.

In order to evaluate the effectiveness of the model and to develop it further, several research studies have been conducted (Seikkula, 1991; Keränen, 1992; Seikkula et al., 1995; Aaltonen et al., 1997; Haarakangas, 1997; Seikkula, Alakare, & Aaltonen, 2000, 2001a, 2001b). In a follow-up outcome study of first-episode psychosis, after 2 years of treatment,

83% had returned to their jobs or studies or were seeking employment, and 77% had no remaining psychotic symptoms. In some cases, problems reemerged with 21% having at least one relapse (Seikkula et al., 2000; Seikkula, 2002). Comparing these outcomes with more traditional treatment in Finland, there were more family meetings, fewer days of inpatient care, reduced use of neuroleptic medication, and a reduction in psychotic symptoms (Lehtinen et al., 2000). We have found that facilitating dialogic communication within the treatment systems is a highly effective approach.

Open Dialogue: The Working Model

Clinical experience and research studies with this model have identified seven key principles, both practically and contextually relevant, that can be applied in all psychiatric crises regardless of the specific diagnosis.

1. *Immediate intervention.* The first meeting is arranged within 24 hours of the first contact made by the patient, a relative, or a referral agency. This immediate intervention allows the treatment team to capitalize on the opportunities provided by the crisis, including mobilizing the patient's and family's social support networks. The crisis frees up formerly untapped resources and moves previously undiscussed issues out into the open, offering unique treatment potential. At this stage all possibilities are open.
2. *The social network and support systems.* Family members and others significant to the patient are invited to participate in the treatment meeting and follow-up treatment as agreed upon. Other support agency members such as social service workers, the patient's employer, health insurance workers, and other hospital employees or supervisors are also invited to take part in treatment.
3. *Flexibility and mobility.* The treatment is adapted to the specific and changing needs of the patient and family. We modify our working practices and integrate specialized therapies and interventions as needed. For example, in a crisis situation, we suggest meeting daily at the patient's home rather than adhering to traditionally prescribed protocols that rigidly define treatment frequency, form, and setting.
4. *Teamwork and responsibility.* The staff member initially contacted is responsible for organizing the first treatment meeting. A team is built according to the needs of the patient with the possibility of including both outpatient and inpatient staff. In the treatment of psychosis, for example, a three-member team is especially suitable: a psychiatrist from the crisis clinic, a psychologist from the

patient's local outpatient clinic, and a nurse from the ward of the hospital. All team members assume responsibility for the entire treatment process.

5. *Psychological continuity.* The team members remain consistent throughout the treatment process, regardless of whether the patient is at home or in the hospital, and irrespective of the length of treatment. For example, a first-episode crisis can be expected to last for two to three years (Jackson & Birchwood, 1996) requiring long-term commitment. Psychological continuity is also critical in the integration of different therapeutic modalities—an integration that can be accomplished through open conversation in treatment meetings.
6. *Tolerance of uncertainty.* In an acute crisis, the therapist keeps all avenues open and avoids hasty conclusions or treatment solutions, such as hospitalization and neuroleptic medication. The team must have faith and confidence in their own work in order to foster hope and trust in the family. Ample time is needed to create a safe working environment for the patient, family, and team members.
7. *Dialogue.* Our focus is primarily on generating dialogue in the treatment meeting among all participants. Dialogue creates new meanings and explanations that introduce possibilities and cooperation for all participants. It is critical that the treatment team create a safe environment so that everything that needs to be said can be openly discussed, which allows for the generation of a new collective understanding about the nature of the problem. Dialogue is seen as a forum in which the patient, family, and team members can create new meanings for the patient's behavior and symptoms (Anderson, 1997; Anderson & Goolishian, 1988; Haarakangas, 1997), helping the family and patient to acquire more agency in their own lives by discussing the problems (Holma & Aaltonen, 1997).

Treatment Meetings

The main forum for therapeutic interaction is the treatment meeting, which is attended by the patient and the immediate people associated with the problem. All management plans and decisions are made with everyone present. In the early 1980s, Alanen and his colleagues invited patients and family members to participate in the meeting. They called these meetings "therapy meetings" because they had documented therapeutic effects. According to Alanen (1997), the treatment meeting has three functions: (a) gathering information, (b) building a treatment plan based on the

diagnosis made in the meeting, and (c) generating psychotherapeutic dialogue. In 1984, patients in Keropudas Hospital were invited to participate in the meeting in which their problems were discussed and the treatment plan was created. In all cases, family members were also invited in as soon as possible after the family member was hospitalized.

In 1987, the hospital created a crisis team that conducted treatment meetings prior to admission to decide whether hospitalization was the most appropriate option. Although these meetings were originally referred to as "admission meetings," alternatives to hospitalization, including home care visits were carefully considered. Research (Seikkula, 1991; Keränen, 1992) has since concluded that home visits are an effective alternative to hospitalization.

Dialogical Equality in Treatment Meetings

Psychiatric treatment has traditionally been very hierarchical. Psychiatrists have made critical treatment decisions that were then carried out by nurses. Psychiatrists have typically made decisions relying strictly on their medical experience, psychological tests, and/or opinions of other experts. Although there has been a certain level of collaboration among various professionals, the knowledgeable voices of the nursing staff in particular have not participated equally in treatment conversations. The psychiatrist has taken an authoritarian position that few nurses have dared to challenge.

Once family-centered treatment and treatment meetings developed, the participation of the patient and relatives became central to the treatment process. As family therapy earned a place alongside individual therapy, a new group of specialists—family therapists—appeared. Early on, many staff members viewed the methods and interventions of family therapists with apprehension and uncertainly, creating a sense of division and thus increasing the reluctance of nurses to take an active role in the meeting.

Given this context, all staff members who participated in treatment meetings at Keropudas Hospital were encouraged to express their observations and opinions concerning the treatment of a patient. Most notably, the family therapists began to ask nurses to describe their impressions of the situation, noting that there is not one single truth but rather many viewpoints which, when communicated, create a sense of shared expertise within a treatment team. Thus, the tacit knowledge of nurses was considered alongside the knowledge of psychiatrists and therapists, allowing their voices to be finally heard.

Although nurses in the Keropudas Hospital had attained some influence and the hospital sought an atmosphere of democracy, hierarchical attitudes seemed entrenched and difficult to change. An experienced mental health nurse commented on her difficult transition from the traditional nonexpert role to the role of contributing expert: "I wondered why he

[the psychologist family therapist] asked me [for an opinion]. I don't know these kinds of things, do I?" To facilitate active participation in the open dialogue process, the head nurse consistently encouraged the nurses to communicate their individual opinions even though it was not traditionally their role. As a result, the nurses' occupational self-esteem improved, and their knowledge became a therapeutic resource.

Furthermore, the patient has long been viewed more as an object of treatment, rather than subject in treatment. Patients have not participated in conversations and decision-making concerning their treatments. After professionals had decided upon a treatment plan, patients were called to hear their decision. Family members were afforded an even more marginal role. Their participation might only have been as a name or note in a case record about near relatives or as an informant in an admission situation. Until the late 1980s, many hospitals did not accommodate family visits due to the stress that was placed on the staff. When the family and patient were finally invited to be a cooperating partner, treatment meetings became a forum for equal therapeutic conversation. The change toward a "polyphonic" treatment culture was not easy, where thoughts and opinions of different people could intermingle as independent, equal voices without one voice dominating or merely accompanying other voices (Bakhtin, 1984).

Multivoicedness in the Treatment Meeting

Multivoicedness is a natural part of family- and network-centered treatment. A "voice" in this context is a metaphor that represents the varying and specific viewpoints expressed within the context of the treatment meeting regarding the theme of conversation (Bakhtin, 1981; Haarakangas, 1997). For example, the viewpoints of workers in an outpatient clinic are different from the viewpoints of workers in a hospital ward. Occupational viewpoints, treatment ideology, and psychotherapeutic orientation vary with the level and type of education, training, and experience. Additionally, voices of the patient and family members usually represent the most intimate connection to the conversational themes in treatment meetings, given that family members are the best experts on their own life. Each person's voice reflects the multiple positions each person simultaneously holds in life. Considering that treatment workers are children of parents, parents themselves, and possibly grandparents, these varied and contradictory positions improve their chances of relating empathically to their clients.

Multivoiced conversation in the treatment meeting contributes to reaching meaningful understandings and therapeutic goals, because it allows for a more comprehensive, multifaceted therapeutic picture. For example, in the treatment of a psychotic patient, the experience and worry

of the family and the team members must be considered from biomedical, psychological, and social perspectives. The patient's own voice including delusional thoughts and words must be seen as an important key to understanding the psychotic world the patient inhabits. Family members can greatly assist in bridging connections between the patient's life events and psychotic experiences. When necessary, various other psychotherapeutic or rehabilitative viewpoints can also be integrated into the treatment meetings. From the viewpoint of therapists, multivoicedness in treatment meetings is challenging. How do we create equality among the different voices? How do we create a safe atmosphere where difficult issues can be freely discussed?

Creating a Safe Atmosphere in Treatment Meetings

The first task in arranging a treatment meeting is appointing a time and place and identifying the participants. When these details are well attended to, clients have the feeling that their concerns are taken seriously, that they are listened to, and that they are cared for. In an acute crisis situation, the first treatment meeting has to be arranged within 24 hours from the first contact. A home visit is often an alternative that increases the sense of safety for family members because clients are on their own turf, and the treatment team members are the visitors. An advantage of home visits is the possibility to see and experience the context of the patient's life more directly than in a therapy room of the hospital or psychiatric clinic. In other cases, the structure and staff of the hospital or health center can provide physical and psychological security and necessary boundaries not available in the home situation. The presence of family members and familiar treatment professionals are especially important in the treatment meetings of a psychotic patient. The responsibility of treatment team members is to ensure that no one experiences physical or psychological threat.

Ample time is required for conversation in a treatment meeting. A suitable time frame has been shown to be an hour and a half, offering enough time to find understanding and create a "safe space" for everyone to participate in the conversation. At the beginning of the treatment meeting there is a phase of mutual coupling (Haarakangas, 1997) during which the participants make acquaintances and develop a connection that allows the conversation to unfold. The customary handshake and other social gestures are an important part of treatment meetings. In the first meeting and when new participants become involved, there is a need for a round of introductions, including participants' names and relationship to the patient, as well as an orientation to the treatment process. Following introductions, the therapist asks the patient and family to talk about their concerns. The therapist aligns his or her words to the patient's and family's, and respects the

definitions and language voiced by each. The therapist can do this by using their words and expressions. The therapist may ask a person to "say more" about a general topic or story and may also ask more specific detail-oriented questions. At the very beginning, it is important to elucidate the onset of the concern, what exacerbated it, who noticed it, who is most worried about it, and what steps have been taken to relieve the worry. The therapist's task in the treatment meeting is to generate a psychologically safe atmosphere in which all members feel free to express what they want to say and to explore their individual worries, pains, and anxieties. And, there is no hurry. The therapist may share personal experiences or how other clients have done well despite the difficulties they face. These stories can give rise to trust and hope. What is needed is time and meaningful conversation with the family as a cooperative partner in the treatment process.

Maintaining conversation and generating dialogue in the treatment meeting is best accomplished in a therapy team of three; two therapists in dialogue while the third takes the reflective position. The team approach helps therapists face the distress and anxiety of a patient and family. High expectations and hopes about alleviating the patient's suffering are laid upon the team, and individual therapists often bear and endure uncertainty and occasional powerlessness as the treatment process progresses. As a team, therapists maintain hope and trust with their clients.

"Dialogicality" in the Treatment Meeting

Conversation in the treatment meeting is geared toward gaining an understanding of the patient's and family's situation. The participants search together for meaning, and through the mutual sharing of different experiences and perspectives, they find understanding. No one—not even the chief psychiatrist—needs to know, nor is it possible to know beforehand, what exactly the "right" solution might be for the patient's symptoms or the difficulties of the family. This position of "not-knowing," described by Anderson and Goolishian (1992), allows for knowledge and understanding to change and develop during conversations in the treatment process. The epistemological basis of this stance is social constructionism (Berger & Luckmann, 1966; Gergen, 1985; McNamee & Gergen, 1992).

Therapists strive to generate conversation in which the varied voices of the participants contribute different meanings; each from a unique but equal participatory place. According to Bakhtin's theory of the philosophy of language (Bakhtin, 1981; Voloshinov, 1996), the speaker's own word and the "other's" word (an "alien" word) meet, penetrate, and change each other. Listening to the other's speech, we are able to integrate their thoughts into our own thinking and consider matters from the other's viewpoint. Our next utterance will have incorporated new meaning from the speech of our

interlocutor and from the meanings they have connected with the theme of the conversation. In this process, meanings change, matters may be considered in a new context, and new understandings can evolve.

Bakhtin (1986) says that "for the word (and, consequently for a human being), there is nothing more terrible than 'lack of response'" (p. 127). Every word and every human being desires understanding and response. In a treatment meeting, the responsibility of the therapist, as a member of the treatment team, is to ensure that everyone feels heard, responded to, and ultimately understood. Although it can be confusing and distressful for the listener, the delusional language of a psychotic patient also seeks to be heard, understood, and responded to. If the patient feels threatened, it is often important for therapists to assure a psychotic patient that they will be protected against the threat. With these words, therapists align themselves as co-partners against the threat. The patient's family members also have to be assured that they have the treatment team's support as well.

If a participant does not talk in a treatment meeting, they can be invited into the conversation by asking if they want to say something about the images that come to mind while listening to the conversation. Those who talk a lot might not be heard in spite of the volume of words or perhaps because of it. In this case, it may be advisable to agree that they can talk long enough to be heard while other participants listen. However, they should spend the same amount of time listening while others talk.

To attentively listen while another person talks and maintain interest in what the other is saying is a difficult but important skill. Do we hear and digest the other's words even though they might taste strange? While listening to the other's speech, we filter the words through our own system of meanings constructed by our personal history. Our personal filters edit for acceptability, comfort, or confrontation, and we seldom actually identify the preconceptions, thinking habits, and defenses we have erected to modify or reject what we have heard. Becoming conscious of one's own prejudices and predictable reactions allows one to reflect on and "suspend" the blocks to real listening. With this clarity comes a maturity as a person and as a therapist—as one who is capable of true empathy—capable of taking the position and the viewpoint of the other. This is a "suspensive" way to be in interaction with other people (Bohm, 1996; Ellinor & Gerard, 1998; Isaacs, 1999).

What we have thus far proposed is characteristic of a "dialogue" and "dialogic conversation." Yankelovich (1999) presents three distinctive features of dialogue that differentiate it from other forms of conversation. First, in dialogue, all participants must be treated as equals. In a treatment meeting, it is possible to generate cooperation among participants from a position of equality because all—even family members—are experts.

All are at the same level of "not-knowing," and their collective goal is to create understanding. The second feature is listening with empathy. Instead of defending one's own opinions, dialogue is characterized by understanding an interlocutor's viewpoint and feelings. The third feature is bringing underlying assumptions to light. The purpose here is to be aware of and inquire into both one's own and the other's assumptions and foundations of thinking and to move them into open dialogue. The attempt to prove one's own point or disprove that of another squarely misses the point. The goal of the open dialogue is to reach a shared understanding.

Dialogue is derived from the Greek word *dialegesthai*, which is the root of *dialogos* (Graumann, 1990). It refers to the fusion of talking and thinking, sharing of meanings "between" two or more partners. Graumann presents a metaphor of moving from two or more positions toward the same place, even if there is "agreement to disagree" as to what that place should be. Bohm's (1996) metaphor is that dialogue is like a "stream of meaning" flowing among, through, and between us. What is needed is space for the free flow of meanings. We have to provide space for people to talk and also to reflect on what they have heard. In the treatment meeting this means that we must not hurry thinking, because the thinking process is unique to the individual's own rhythm and readiness.

Reflective Activity of the Treatment Team

In the treatment meeting, therapists stand knee-deep in a stream of meanings. In dialogue, words emerge and vanish, then reappear and change. Some words carry special weight; they may be so emotionally charged that just saying them affects body language, and the speaker has difficulty keeping his or her passion in check. Sometimes, feelings surface for which words seem unavailable. When empathically listening, therapists are sensitive to both fully worded and wordless emotional messages.

A dialogical moment can pass without notice or can be captured by a therapist who identifies and reflects on a word that seems of great significance to the speaker. For example, when a patient names a fear using a particular word, a therapist explores what other words are contained within that word and what different feelings are connected with them. "Cancer is a serious and frightening word to many people. What words do you connect with it"? As evidenced by the question, this method is skillfully and sensitively applied by Professor Tom Andersen of Tromsø University who specializes in capturing fleeting dialogical moments and moving those defining words of a client's life into conversation.

Therapists do not float like pieces of driftwood in a stream of meaning. Therapeutic skill involves identifying therapeutically significant issues that clients cannot yet talk about. Mutually reflective conversation

between therapists with a patient, with a family listening, is a method in which therapists take into conversation difficult but important issues and make them less threatening to the family. Vygotsky's (1992) concept of the zone of proximal development in education is similar to the idea of potential "discourse in therapy" (Haarakangas, 1997) or speech that is created by therapists in "reflective dialogue."

In reflective dialogue, members of a treatment team engage in mutual dialogue about the observations, thoughts, and images that are raised in the treatment meeting and, in reflecting, address their words to other team members rather than to the patient and family. The patient and family are thus afforded the opportunity to listen to the therapists' conversation without taking part in it, taking a stand, or responding to it. From the standpoint of the patient and family, the conversation between therapists can be a therapeutic context within which they clarify their own experiences and meanings. The therapeutic skill of team members finds expression in their ability to maintain respect for the patient and family, carefully balancing their comments so as not to offend or gravely disagree with the observers (Andersen, 1991). At its best, reflective dialogue is flexibly connected to other conversations to assure that the patient and family do not experience it as foreign or embarrassing. By reflecting subjective images, team members help shape the treatment meeting conversation into a form that the patient and family understand as personal opinion and thought—not fixed and final psychiatric truth.

Questions from therapists to the patient and family can also be reflective concerning their goals. Some therapeutically effective questions suggested by Tom Andersen are: If your fist that is ready to strike could speak, what would it say? What would your tears want to say? What other feelings does the pain you mentioned contain? Family members can also be asked about the thoughts aroused by conversation or asked to comment on the opinions of other participants.

Conversation in treatment meetings is a continuous reflective process where inner and outer dialogues alternate. A therapist should maintain inner dialogue with their own minds and bodies during the process by checking in with themselves asking, for example: Why do I think and feel like this right now? Why do I feel so uncomfortable now? Is it because of this conversation or is it because of my background or assumptions? A therapist can move their inner dialogue or emotional experience into conversation with other members of the therapy team during the treatment meeting. In a reflective dialogue between therapists, differences and similarities in observations and experiences can be explored. As manifested and modeled in the thinking and behavior of the therapists, reflectivity seeks to arouse in patients a reflective relationship to their situation.

Closing Thoughts

Since the early 1980s, we have been developing our work toward open dialogue. In the process, we have evolved from being "experts" to becoming "dialogicians." This present stance allows us more flexibility, thus increasing our options. The open dialogue method has also transformed the patient into coworker and therapists into active listeners. In the Finnish language, we would call the work of supporting of families caught in a mental health crisis "walking together."

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