Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXII, n. 3, 2021
doi:10.4081/rp.2021.529

Open Dialogue - a new psychotherapeutic and human rights approach to build up humanistic psychiatric services

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ABSTRACT. – Mental health services should guarantee immediate help in crises including the nearest to the patients. Open dialogue while doing this has changed the emphasize into sensitively listening to the voices of the patient and those nearest to him/her instead of looking at the psychopathology. The documented results in most sever crises like psychosis are exceptional with significantly less use of medication. In this paper the main focus is to describe how to generate dialogue in the open meetings with the team, the person in the centre of concern and the family members present and thus mobilizing their own psychological resources for recovery.

Key words: Open Dialogue; social networks; psychosis; family therapy; psychotherapy.

Introduction

In a severe mental health crisis, it should be normal psychiatric practice for the first meeting to take place within a day of hearing about the crisis. Furthermore, both the patient and family members should be invited to participate in the first meeting and throughout the treatment process for as long as is needed. In these meetings all relevant professionals from primary care, psychiatry, social care and other appropriate services, who have contact with this family are invited to participate and they openly share their thoughts and opinions about the crisis and about the actions needed. These professionals should stay involved for as long as required. All discussions and treatment decisions should be made openly in the presence of the patient and family members.

These are the basic guiding principles of the Open Dialogue approach, a treatment method that originated in the Western part of Finnish Lapland. The

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development of this new approach started in the early 1980s and now is put into practices in about 30 countries.

Opening the boundaries

When starting to develop the acute psychiatric inpatient system at Keropudas Hospital in Tornio the team had two primary interests. In the beginning, there was an interest in individual psychotherapy with patients diagnosed with schizophrenia. At that time Keropudas Hospital was occupied by dozens of long-term patients who had been considered 'incurable' and were to be transferred to another mental hospital designated to receive patients who needed long-term inpatient treatment. In shifting to a more optimistic treatment model, the Keropudas staff had to learn how to work with the psychological resources of the patients in any type of acute crises. In Finland, psychotherapeutic practice has long been part of public health care. Particularly important has been the development and research undertaken in the Turku Psychiatric Clinic by Professor Yrjö Alanen and his team since the 1960s. Starting with individual psychodynamic psychotherapy, the Turku team integrated family perspectives into their treatments in the late 1970s and called the approach Need-Adapted treatment (Alanen, 1997) to emphasize that every treatment process is unique and should be adapted to the varying needs of each patient.

The revolutionary elements of the Need-Adapted approach were to focus on: i) rapid early intervention in every case; ii) treatment planning to meet the changing and unique needs of each patient and family by integrating different therapeutic methods in a single treatment process; iii) having a therapeutic attitude as the basic orientation for each staff member in both examination and treatment; iv) seeing treatment as a continuous process; and v) constantly monitoring treatment progress and outcomes (Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991).

In the era of evidence-based medicine all this sounds very radical because it challenges the idea that therapists should choose the one right method of treatment after first making an accurate diagnosis of the case. By contrast, need-adaptiveness focuses on the idea that the 'right' diagnosis *emerges* in joint meetings. It became clear to us developing the new approach that the use of dialogue to reach a full understanding by all concerned of what had happened can of itself be a very therapeutic process.

Anticipating psychotherapy research into common factors, by the early 1980s the Need-Adapted approach was already integrating different psychotherapies instead of choosing just one method such as systemic family therapy or individual psychodynamic psychotherapy. Having the background on the long tradition of psychotherapy of schizophrenia in Finland, in Western

Lapland the Open Dialogue approach meant that psychotherapeutic treatment was organized for all patients within their own particular social network. This really concerns all the patients both in outpatient and inpatient care and as well all the diagnostic categories, not only psychotic patients.

Open dialogue refers both to the way the psychiatric system is organized and to the role of dialogue in the meetings with the patient, family members and professionals. The term Open Dialogue was first used in 1995 (Seikkula *et al*., 1995) to describe the entire family and social network-centred treatment. It has two aspects: first generating dialoguers in the meetings, in which all relevant members participate from the outset and secondly the guiding principles for the entire psychiatric system in one geographical catchment area.

The effectiveness of the *Open Dialogue* approach has been confirmed in several studies mainly in psychotic and major depression crises. In the latest study it was found that in psychotic crises the long term outcomes (approximately 19 years) in the *Open Dialogue* system of care in Western Lapland were significantly better in relation to the treatment as usual in the rest of Finland (Bergström *et al*., 2018).

As seen (Table 1) in *Open Dialogue* care in Western Lapland the patients were significantly less hospitalized, the had significantly less neuroleptic medication at the outset of care and at 19 years follow-up, they had significantly less ongoing treatment contact and most strikingly, they were living on a disability allowance in one third of the situations compared to two thirds in the rest of Finland. These outcomes really seem to refer a treatment of entirely different culture compared to the traditional psychiatry.

Open dialogue meeting with the team and the client(s)

In the *Open Dialogue* approach, when a person or family in distress seeks help from the mental health system, a team of professionals is mobilized to

Table 1. Psychiatric treatment and disability pensions in psychotic crises approximately 19 years after the start of treatment.

	OD (N=108) (%)	**TAU (N=1763) (%)**	**Chi-Square-test**	
			x^2	**P**
30 or more hospital days at onset	18.5	46.8	32.4	0.000
Neuroleptics started at onset	16.7	75.5	389.7	0.000
Treatment contact at follow-up	27.8	49.2	16.7	0.000
Neuroleptics used at follow-up	36.1	81.1	110.4	0.000
Disability pension at follow-up	33	61	28	0.000

OD, Open Dialogue; TAU, treatment as usual.

meet with the family and concerned members of the family's network as promptly as possible within 24 hours, usually at the family's chosen familiar location. The team remains assigned throughout the treatment process, whether it lasts for months or for years. No conversations or decisions about the situation of care are conducted outside the presence of the network. Evaluation of the current problem, treatment planning, and decisions are all made in open meetings that include the one in the centre of concern, his or her social relations, and all relevant authorities. Specific services (*e.g*., individual psychotherapy, vocational rehabilitation, psychopharmacology, and so on) may be integrated into treatment over the course of time, but the core of the treatment process is the ongoing dialogue in treatment meetings among members of the team and network.

The main forum for dialogues is the open therapy meeting where the major participants in the problematic situation join with the patient to discuss all the relevant issues. One of the founders of the Need-Adapted approach Yrjö Alanen (Alanen *et al*., 1991) noted that overall, the focus is on strengthening the adult side of the patient and on normalizing the situation instead of focusing on regressive behaviour. The starting point for treatment is the language the family use to describe the patient`s problem. Problems are reformulated in every conversation (Bakhtin, 1984; Shotter, 1993). All persons present speak in their own voices. The stance of the therapist is different compared with the traditional one in which it is the therapist who makes the interventions.

While many family therapy schools concentrate on creating specific forms of interviewing, the dialogic approach focuses more on listening and responding.

The meeting takes place in an open forum with all participants sitting in a circle. The team members who have initiated the meeting take charge of facilitating the dialogue. On some occasions there is no prior planning regarding who initiates the questioning and thus all staff members can participate in interviewing. On other occasions the team may decide in advance who will conduct the interview. The first questions are as open- ended as possible, to guarantee that family members and the rest of the social network can begin to talk about the issues that are most relevant at that time. This means that the teams do not open the meetings with their agenda and with their definition about what would be the most important issues to speak about. The team does not plan the themes of the meeting in advance. From the very beginning the task of the interviewer(s) is to adapt their answers to whatever the clients say. Most often the team's answer takes the form of a further question that is based on, and has considered, what the client and family members have already said. This can mean repeating word by word some part of the utterance and encouraging further dialogue on the subject. If the patient does not want to participate in the meeting or suddenly runs out of the meeting room, a discus-

sion takes place with the family members whether to continue the meeting. If the family wants to continue, a staff member informs the patient that she or he can return if she or he wants. During this discussion no other decisions concerning the patient are made.

Everyone presents has the right to comment on whatever subject they want. Every new speaker should adapt his or her utterance to what was previously said. For the professionals this means they can comment either by inquiring further about the theme under discussion, or by commenting reflectively to the other professionals openly about their thoughts in response to what is being said (Andersen 1995). Often, in these comments, specific phrases are introduced to describe the client's most difficult experiences.

When the staff members must remind about their obligations and duties in this specific treatment process, it is advisable to focus on these issues towards the end of the meeting after family members have had the opportunity to speak about their most compelling issues. After deciding that the important issues for the meeting have been addressed, the team member in charge suggests that the meeting be adjourned. It is important, however, to close the meeting by referring to the client's own words and by asking, for instance: *'I wonder if we could take steps to close the meeting. Before doing so, however, is there anything else we should discuss?'* At the end of the meeting it is helpful to briefly summarize the themes of the meeting, especially whether or not decisions have been made, and if so, what they were. The length of meetings can vary, but ninety minutes is usually adequate.

Emotional problems appear in tension loaded relationships

In their acute distress, network members often appear stuck in desperate, rigid, constricted ways of understanding and communicating about the problems that absorb them. In open treatment meetings, team members solicit contributions from every network member, especially included the one who may for instance have psychotic ideas. Everyone's utterances are listened to carefully and responded to respectfully.

Team members support the expression of emotion. They respond transparently and authentically as whole persons. Transparent about being moved by the feelings of network members, the team members' challenge is to tolerate the intense emotional states induced in the meeting. Their conversations among themselves in the presence of the network serve the function of generating reflective processes, expanding the network members' possibilities for making sense of their experiences. Particularly in the beginning phase of treatment, decisions are deferred in favour of expanding and extending the conversation, enabling the system to tolerate ambiguity in the context of extreme stress. This makes it possible to entertain new ideas for addressing

the troubled situation. At the beginning, team members are careful to incorporate the familiar language of the network members into their own utterances. As team members respectfully and attentively draw out the words and feelings of each network member, the conversation shifts. As the original network incorporates the team into its membership, new meanings emerge when new shared language starts to emerge between the team and members of the social network. The drama of the process lies not in some brilliant intervention by the professional, but in the emotional exchange among network members, including the professionals, who together construct or restore a caring personal community.

Generating dialogue to mobilize the psychological resources

The meetings are organized with as little preplanning as possible. One or more team members lead the meeting. With everyone sitting together in the same room, in the beginning, the professional helpers share the information that they may have about the problem. The leader then offers an open-ended question asking, for instance who would like to start or how would they like to use the time for best helps for everyone. The form of the questions is not preplanned; on the contrary, through careful attunement to each speaker, the leader generates each next question from the previous answer, *e.g*., by repeating the answer word for word before asking the question or by incorporating into the language of the next question the language of the previous answer. It is critically important for the process to proceed slowly to provide for the rhythm and style of each participant's speech and to assure that each person has a place created in which he or she is invited and supported to have his or her say. As many voices as possible are incorporated into the discussion of each theme as it emerges. Professionals may propose reflective conversation within the team whenever they deem it adequate. After each reflective sequence, network members are invited to comment on what they heard. When the leader proposes to close the meeting, the participants are encouraged to say if there is something they want to add. Each meeting concludes with the leader or leaders summarizing what has been discussed and what decisions have been or should be made.

Everyone should be listened and respected without conditions

One of the main authors for dialogical perspective in human life was a Russian philosopher Mikhail Bakhtin's (1975), who used to say that '*for the word (and consequently for a human being) there is nothing more terrible than a lack of response*' (p. 127). Respecting the dialogical principle that

every utterance calls for a response to have meaning, team members strive to answer what is said. Answering does not mean giving an explanation or interpretation, but rather, demonstrating in one's response that one has noticed what has been said, respect it without any conditions and when possible, opening a new point of view on what has been said. This is not a forced interruption of every utterance to give a response, but an adaptation of one's answering words to the emerging natural rhythm of the conversation. Team members respond as fully embodied persons with genuine interest in what each person in the room has to say, avoiding any suggestion that someone may have said something wrong.

As the process enables network members to find their voices, they also become respondents to themselves. For a speaker, hearing her own words after receiving the comments that answer them enables her to understand more what she has said. As Bakhtin said it:

> '*Dialogue here is not the threshold to action, it is the action itself. It is not a means for revealing, for bringing to the surface the already-made character of a person; no, in dialogue a person not only shows himself outwardly, but he becomes for the first time that which he is - and we repeat, not only for others but for himself as well. To be means to communicate dialogically*.' (Bakhtin, 1984, 262).

Using the everyday language with which clients are familiar, team members' questions facilitate the telling of stories that incorporate the mundane details and the difficult emotions of the events being recounted. By asking for other network members' comments on what has been said, team members help create a multivoiced picture of the event. In reflective dialogue, team members are carefully directing their comments and their gazes toward each other rather than toward the network members, and commenting to each other about their observations, team members construct new words in a very concrete fashion (Andersen, 1991). It is as important for team members to engage each other in dialogue about each other's comments as it is to make the comments themselves. The team dialogue affords the network members a more colourful picture of their own situation, and everyone is afforded more possibilities for understanding what is going on.

Although the content of the conversation is of primary importance for the network members, the primary focus for the team members is the way that the content is talked about. More important than to follow some specific methodological rule is to be present in the moment, adapting their actions to what is taking place at every turn in the dialogue. Every treatment meeting is unique; all the issues addressed in prior meetings gain new meanings in the present moment. They include what we may remember from the earlier dialogues but also include something completely new, experienced for the first time. The team members' task is to open a space for these new, not previously spoken meanings (Anderson & Goolishian, 1988). Team members avoid speaking

too rapidly or moving toward conclusions. Tolerating a situation in which no ready-made responses or treatment plans are made available enables network members to make use of their own natural psychological resources. As multiple voices join in the sharing of the situation, new possibilities emerge. These possibilities seldom emerge as a single unambiguous response to the question of how to go on. Different network members live in different, even contradictory, situations, and thus may have quite different ideas of the problem. Consider a crisis surrounding a mother, father, and son, in which the son, suspected of drug abuse, becomes nearly psychotic. The father may be concerned primarily about the family's reputation among his co-workers and the mother about her son's health, and the young man may protest angrily that he does not need any treatment and that his parents are crazy and should seek treatment for themselves.

Normalizing discourse

Committed to responding as fully embodied persons, team members are acutely aware of their own emotions resonating with expressions of emotion in the room. Responding to odd or frightening psychotic speech in the same manner as any other comment offers a 'normalizing discourse,' making distressing psychotic utterances intelligible as understandable reactions to an extreme life situation in which the patient and her nearest are living. Understanding does not imply dismissal or minimization of the difficulties experienced; the team member's response resonates with the degree of distress and difficulty uttered. Indeed, sometimes team members offer enhanced opportunity for network members to express feelings of hopelessness. This contrasts with a solution-oriented approach in which the therapist tries to find more positive words to construct experience. It is important that the emotions of the family members connected to the 'not-yet-spoken' experience are expressed openly in the meetings in the presence of the most important people in one's life. By making it clear that the team will remain involved with the network throughout the treatment, by assuring that all treatment decisions are jointly discussed and decided, by exploring intensely emotional themes in a calm, engaged manner, and by consistently seeking contributions from all the participants, team members provide reassuring predictability about the intervention process. Network members learn that they can rely on the professionals to help them remain engaged in conversations about difficult and distressing matters that had not been successfully contained in conversation before.

Having the focus on shared emotional experience was the origin of network therapy (Seikkula *et al*., 1995; Speck & Attneave, 1973; Van der Velden, Halevy-Martini, Ruhf, & Schoenfeld, 1984). The crisis that moves network members to seek help contribute to the powerful emotional 'loading' of a

meeting. Responding as whole persons, team members' share these emotions and can show their own movement. Their calm, respectful way of talking is paced to allow full experience and expression of feelings in the meeting. If team members try to move the conversation forward too quickly at such moments, there is a risk that it will take place solely at a rational level. The most difficult and traumatic memories are stored in nonverbal bodily memory (Van der Kolk, 2006). Creating words for these emotions is a fundamentally important activity. For the words to be found, the feelings must be endured. Employing the power of human relationships to hold powerful emotions, network members are encouraged to sustain intense painful emotions of sadness, helplessness, and hopelessness. A dialogical process is a necessary condition for making this possible. To support dialogical process, team members attend to how feelings are expressed by the many voices of the body: tears in the eye, constriction in the throat, changes in posture, and facial expression. Team members are sensitive to how the body may be so emotionally strained while speaking of extremely difficult issues as to inhibit speaking further, and they respond compassionately to draw forth words at such moments. The experiences that had been stored in the body's memory as symptoms are 'vaporized' into words.

Best in most severe crises

On many occasions it has been observed that the heavier the experiences and emotions lived through together in the meeting, the more favourable the outcome seems to be. Before the meeting, network members may have been struggling with unbearably painful situations and have had difficulty talking with each other about their problems. Thus, they have estranged themselves from each other when they most need each other's support. In the meeting, network members find it possible to live through the severity and hopelessness of the crisis even as they feel their solidarity as family and intimate personal community. These two powerful and distinct emotional currents run through the meeting, amplifying each other recursively. Painful emotions stimulate strong feelings of sharing and belonging together. These feelings of solidarity in turn make it possible to go more deeply into painful feelings, thus engendering stronger feelings of solidarity, and so on. Indeed, it appears that the shift out of rigid and constricted monological discourse into dialogue occurs as if by itself when painful emotions are not treated as dangerous, but instead allowed to flow freely in the room (Trimble, 2000; Tschudi & Reichelt, 2004).

It is important to remember that all the members of the network are struggling with the emotionally loaded incidents and experiences that constitute the crisis, albeit from different positions. Family members may have acted to bring on the crisis, lived through the effects of the crisis, or both. The hallu-

cinations of a patient having psychotic problems may incorporate traumatic events in metaphoric form. Although the symptoms' allusion to the traumatic events may thereby be inaccessible to other participant present in the meeting, they themselves may have been affected by those same events, and their own embodied emotional reactions are stimulated. The emotional loading from these collective interactions and amplifications of emotional states make the network meeting quite different from a dialogue between two individuals.

The emotional loading in the meeting seldom manifests as a huge explosion or catharsis. It emerges most often as small surprises that open new directions for dialogue. By its nature, the emotional exchange occurs in the immediate moment, and the experience cannot be moved as such to another time or place. The outcome of the meeting is experienced more in the embodied comprehensive experiences of the participants than in any explanations offered for problems or decisions made at the end of the meeting. This may be unusual for professionals used to working in a more structured way. Participants' language and bodily gestures would begin to express strong emotions that, in the everyday language used in meetings, could best be described as an experience of love (Seikkula & Trimble, 2005). This is not a romantic love, but rather another kind of loving feeling found in families absorbing mutual feelings of affection, empathy, concern, nurturance, safety, security, and deep emotional connection. Once the feelings become widely shared in the meeting, the experience of relational healing become palpable. This is what the families in manty follow-up studies have informed taking place. They can say, for instance, that the beginning of the crisis was very painful when not knowing what is going to happen. But step by step they learned to love each other in the way that they had lost of some terrible incident in their lives.

Team helps to move from looking at symptoms to scrutiny of life and tolerating uncertainty

The activity of constructing new shared language incorporating the words that network members bring to the meetings and the new words that emerge from dialogue among team and network members affords a healing alternative to the language of symptoms or of difficult behaviour. The team helps cultivate a conversational culture that respects each voice and strives to hear all voices. Essential team actions toward this purpose include the following:

i) Asking for information in a manner that makes telling the stories as easy as possible and less distressing as possible. This includes using everyday language, pursuing details, and inviting comments on people's responses, thus generating a multivoiced picture of an incident.
ii) Listening intently and compassionately as each speaker takes a turn and making space for every utterance, including those made in psychotic

speech or in other types of agitated behaviour. Showing appreciation for the extreme life situations that engender psychotic ideas and feelings of hopelessness.

iii) Conducting reflective dialogue among team members, commenting not only on the network members' utterances but also on each other's utterances about the network members' utterances. This recursive process helps team members, other professionals in the meeting, and network members to tolerate the uncertainty of a situation in which there are no rapid responses for difficult problems and no rapid treatment decisions. By tolerating this uncertainty, network members discover in their sharing of the situation the psychological resources for answering the question of how to go on.

After team members have entered the conversation by adapting their utterances to those of the one in the centre of concern and her nearest relations, the network members may in time come to adapt their own words to those of the team. It helps one to understand more when one experiences the other as understanding oneself. If one discovers that one is heard, it may become possible to begin to hear and become curious about others' experiences and opinions. Together, team and network members build up an area of joint language in which they come to agreements about the particular use of words in the situation. This joint language, emerging in the area between the participants in the dialogue, expresses their shared experience of the incidents and the emotions embedded in them (Haarakangas, 1997). By listening to the reflective dialogue of team members, network members discover new possibilities for meaning about the situation. From the reflective internal dialogues emerge new ways of understanding the problem situation that, as they are then spoken aloud, lead the group dialogue into new, previously undiscovered possibilities.

Just as symptoms are comprehensive, embodied experiences, so is the new language generated through comprehensive, embodied experiences more than by rational explanation. It has become evident this being strongly an embodied process of synchronization between all the participants in the meeting (Seikkula *et al*., 2018). In the study of Relational Mind we had the possibility to look at the embodied participation in the therapy dialogues. It was noted that in a point of high arousal in the autonomic nervous system of the therapy clients and therapists new dialogical understanding seldom occurred. The dialogical change often started after the arousal point when people started to calm down. It seems important to leave place for the arousal, for instance feeling the sadness without any meaning making comments by the therapists. After calming down there are more adequate options to make reflective questions, in which the clients have the possibility to form words to their experiences. As network members share feelings of togetherness, they begin to give voice to the not-yet-said. Sharing difficult issues may feel threatening if previous attempts have led to painful failure. One learns that starting to be open

with one's own experiences often means that others present at the meeting, even the silent ones, themselves become more open and more able to trust in each other and in the belief that difficult issues are possible to handle. As team and network live through the experiences that thus find their way into the room, their shared emotional experience allows the familiar words of network members to be organized into new understandings, stories in which each participant can address his or her own trauma and handle his or her own emotions. It is when the new language captures the original, unexpressed, distressing story and the context from which the symptoms first emerged that the dialogue begins to compensate symptoms. As network members find language for their traumatic experiences, both the situations described, and the emotions associated with them become controllable. The healing factors contribute to the creation of community. Community is sustained and revitalized by collective sharing of powerful feelings, with the reciprocal attunement process drawing forth our most profoundly human relational capacities.

Ideal ways for organizing dialogues in the network

Open dialogue was first initiated in the Finnish Länsipohja province, in the western part of Lapland. For this reason in the English literature, it is named as Western Lapland. During the development of the approach several studies were conducted to understand the new system of care and to develop it's practices. In these studies, it was noted that optimal dialogue seems to presuppose the system of care being organized in the optimal way. The system of treatment is guided by seven main principles, established in a research project in the mid-1990s (Aaltonen *et al*., 2011). Hence of an optimal care in serious crisis: i) the first meeting should be organized immediately in the crisis, within 24 hours of contact being made with the mental health services; ii) the social network of the patient, including the family and the professionals working with this specific family, should always be invited to participate, from the outset and for as long as required; iii) the treatment should be flexibly adapted to the specific needs of the patient and the family, using the therapy methods most suited to the case in question. The core idea is to integrate the different methods of therapy in the most optimal way; iv) the mental health systems should guarantee that specific persons/teams will take responsibility for the treatment, organizing a case-specific team that will make decisions together with the family concerning all the treatment planning and actions to be taken; v) the team should aim to guarantee psychological continuity by inviting staff members from different facilities to collaborate, for as long as required; vi) the process should tolerate uncertainty and for enhancing this the team should aim at promoting a sense of security, generating a therapeutic process of sharing in order to mobilize the psychological resources of

the family and the social network; vii) the team should focus on generating dialogue in the joint therapy meetings, to create new words and a new joint language for experiences that previously did not have words.

A situation in which two persons were in need for help at the same time

To shortly illustrate, how the system of care is working and how the dialogue occurs in the meetings I will present a case that was a part of the abovementioned research projects of first episode psychotic patients in *Open Dialogue*. Lisa's twin brother had been brought into primary care during the weekend following a suicide attempt (Seikkula *et al*., 2001). On Monday morning, his general practitioner contacted a psychologist at the local mental health outpatient clinic. Because of being a part of the *Open Dialogue* community care, in the province a specific acute crisis polyclinic is available for guaranteeing the meeting being organized immediately. He took immediately contact to the crisis polyclinic and they together organized a team consisting, in addition to himself, of a nurse from the same outpatient clinic and a doctor and a psychologist from the crisis polyclinic. The team made a home visit the same day in the afternoon. Present at the first meeting were Lisa, her mother, father, twin brother, and a younger brother. Lisa started to talk about her own personal philosophical theories and about her delusions of seeing people with the head of a bull. The team tolerated this unexpected story and started to talk with Lisa and the rest of the family. They were somewhat surprised, as they were under the impression that they had come for Lisa's twin brother, but her mother told them that they were worried about both siblings. It emerged soon that in fact had severe psychotic ideas.

They said that Lisa had returned home one year earlier, and both twins had isolated themselves during the preceding four-month period. It appeared that Lisa had had psychotic ideas for 25 months and did not have any other relations outside the family. Her twin brother had followed her to their cabin - in which they were living now - five months before and now during the weekend had taken an over doze of tranquilizers.

Open treatment meetings were organized daily at the beginning. Especially the first one was quite agitative because of the quarrel that appeared between Lisa and his father. Lisa especially accused father of being gruel to his son years ago while forcing him to run sports. Father became furious about these accusations and later they told that their quarrel had continued during the evening at home after the team had left. During the first two months, nine meetings were organized altogether. After the two first meetings with a lot of quarrel the meetings developed an increasingly psychotherapeutic quality and many episodes of reflective discussion between the team members emerged. In the sixth and seventh meetings, Lisa again expressed anger

and hatred towards her father owing to her perceptions of his behaviour during their childhood. It seemed that, for the first time, it had become possible for her to construct words to describe her difficult experiences with her father.

At the beginning of the process, the general practitioner prescribed neuroleptics, which Lisa tried to take on five occasions but eventually decided to discontinue because, as she said in the two-year follow-up interview, 'all the world became dark and immobile, I did not have any thoughts left.' After two months, individual psychotherapy was started with a psychologist who was a member of the crisis team. This was done in a joint understanding after being proposed by the team. During this phase, Lisa still occasionally had prominent psychotic experiences. After six months, Lisa decided to stop the psychotherapy, moved away from home, and did not respond to the contact attempts of the doctor who wanted to know how she is doing.

Because of being a part of a study follow-up interviews with the family weas organized after two and five years. In the two-year follow-up interview, she said that she had started to study philosophy, and that she had no remaining psychotic symptoms. She had decided that she herself had to find a way out of her problems, and that was why she had discontinued the psychotherapy and moved away. She also said that she had realized that it was not good for her to live near her family, since this easily led to quarrels. It was better for her to live without too many contacts with her family. She had had psychotic delusions for about half a year after discontinuing the psychotherapy, but, since then, the symptoms had not recurred. In the five-year follow-up interview, she said that she had taken a break from her studies. She had been working as a full-time cleaner for three years' time, was married and talked about their plans to have a baby.

The seven principles had been realized to an adequate extent. The first meeting had taken place immediately on the same day after the contact with the general practitioner, and the closest social network was involved from the outset, although the motivation of the parents subsequently declined. The same team guaranteed psychological continuity throughout the process, including the shift from family sessions to individual psychotherapy. The process allowed for tolerance of the uncertain periods of hallucinatory talk and the hatred Lisa expressed towards her father. During the many critical phases of the process, dialogue was generated and maintained. This was already evident at the first meeting, in which the team did not focus on diagnosing the psychosis, but rather emphasized generating a dialogue in which the family could present the problem in their own language.

Discussion and conclusions

A unique quality of the *Open Dialogue* approach is it's intertwined con-

nection to all the time ongoing research in the natural setting (Seikkula, 2019). When started to develop the practice in the Finnish Western Lapland early 80's, after the first confusing experiences in the new open practice it was noted the importance to start to inquire about the basic ideas of the treatment processes and about the outcomes of the new approach. Since 1988 all the time ongoing studies have been regular part of the system and the approach has been developed based on the research. The ideas of dialogical practice have born in the studies about the processes of open meetings and the concept of *Open Dialogue* as the conclusion about the entire community care system was born as an outcome of one qualitative content analysis. The importance of this research is not primarily for having the information about the effectiveness to inform the outside community about it, but the opposite. The research is needed to develop the practice.

The second essential element of the *Open Dialogue* approach is the all the time ongoing training of staff and in many places of the people with their own lived experience. In Tornio, the training was planned to be for three years and guaranteeing the license of psychotherapists according to Finnish law. In most places nowadays the training is one year education for the teams to learn to work together in dialogical ways.

As moving out to the world from the Western Lapland, *Open Dialogue* has received a lot of different applications in respect to the cultural differences concerning the administration and organizations of health care. What has surprised me is the general quality of dialogues in the meetings. The dialogues really seem to taka the same type of path in Open Dialogue meeting in China as in United States or in Italy. Regardless of the important cultural differences of life, the dialogue seems to follow the same lines. It is basis of human life in whatever context.

The second phenomena to pay a lot of attention is the challenge of adopting dialogical skills. Some places the basic ideas have been adopted easily, in some places it really includes challenges both in the ways to organize the system of care and in the ways to participate in the meetings. Some studies have analysed the experiences in the training programs. *Open dialogue* training is often distinct from traditional learning and is based on experiential approach to learning, which has been reported to generate strong emotional experiences (Buus *et al*., 2019; Pope *et al*., 2016; Stockmann *et al*., 2017). Pope *et al*. (2016) found that the need-adapted training lacked the instructional clarity of more manualised training programs, and some participants found the training disorganised. Putman (2015) refers to Open Dialogue training as having an aspect of 'unlearning' that can take many forms. This is because 'prior' learning - through both personal development and conventional professional learning - can be highly limiting in Open Dialogue contexts. Schubert *et al*. (2020) explored the professional identity of Australian clinical psychologists and psychiatrists

after their introductory Open Dialogue training. The training could facilitate opportunities for taking alternative positions in their clinical work that to a larger extent involved their personal selves, and which sometimes was perceived as exposing and putting the clinician in a vulnerable position.

For me all these comments make perfect sense according to my experiences of being in charge of the training programs. The challenge is to find a balance between structure that is always needed while learning new skills and the dialogical uncertainty that is always needed to learn dialogical skills especially.

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Conflict of interests: the author declares no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received for publication: 17 February 2021.
Accepted for publication: 12 June 2021.

Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2021; XXXII:529
doi:10.4081/rp.2021.529