

## **Open Dialogue Approach – about the phenomenon of Scandinavian Psychiatry**

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### **Summary**

After twenty years of transformation of Finnish mental health care, in the late 80s and early 90s of the last century, incidence of schizophrenia in Western Lapland dropped from 35/100,000 to 7/100,000. This phenomenon is linked with Yrjö O. Alanen et al. who investigated schizophrenia treatment outcomes and psychosocial rehabilitation of people with schizophrenia. Investigators focused on an individually tailored psychotherapeutic recovery plan during patient's hospitalisation, including care for patients' families. Within the "Finnish National Schizophrenia Project" the principles of the Need-Adapted Treatment were created and 50% of Finland's country gained access to mobile crisis intervention teams. Further studies were continued within "Acute Psychosis Integrated Treatment Project" (1992–1993) which locally, in Western Lapland, proceeded into "Open Dialogue in Acute Psychosis Project" (ODAP) (1994–1997). In this approach, all important decisions regarding the patient, including hospitalisation or pharmacotherapy, are discussed not only with the entire therapeutic team, but also with the patient and his family members. Two – and five-year follow-ups demonstrated high treatment efficacy as well as important cost reduction in mental health care spending. First two "Open Dialogue Method" training courses for representatives of the medical, psychological, nursing and social care have been completed in Poland in October 2014. Studies evaluating the therapeutic effectiveness of the described approach are being planned.

**Key words:** community psychiatry, Open Dialogue, psychotic disorders

### **Introduction**

In Finnish Western Lapland, the most northern part of Finland inhabited by nearly 70 thousand people, mental health care has undergone deep transformation since the beginning of the 1980s. This metamorphosis led to a withdrawal from protracted

institutionalised inpatient care towards community based interventions. One of the consequences of the transformation of psychiatric care was developing a novel method of treating patients experiencing a first psychotic episode. The innovative model helped to significantly reduce pharmacotherapy (in 1998 an average of 29% of patients were treated with antipsychotics [1, 2]), putting the emphasis on psychosocial therapies. Seikkula et al., presenting the results of a five-year follow-up of patients experiencing their first psychotic episode, did not find the presence of residual psychotic symptoms in 82% of them, and 76% of those surveyed took a job/studies [1]. The treatment protocol developed by Alanen was called Need-Adapted Approach (NAA) and its further development in Western Lapland resulted in the formulation of the Open Dialogue Approach (ODA) by Seikkula [1]. With time treatment tailored to the needs aroused great interest of researchers from abroad who implemented its elements in their countries, achieving comparable results. In Scandinavian countries, Yrjö O. Alanen together with Endre Ugelstad created the Nordic Investigation on Psychotherapy of Schizophrenia (NIPS) [3], while in Sweden John Cullberg coordinated the Parachute Project [4].

Nonetheless, in spite of positive therapeutic outcomes, the period of implementation of those changes was difficult for the Finnish researchers due to a worsening economic situation of Finland. At the beginning of 1990s, Finland experienced a deep financial crisis, which led to a 30% cut in mental health care spending [5]. Fortunately, this challenging economic situation did not discourage researchers from addressing the problem of the highest schizophrenia rate in Europe (35/100 thousand) or the second highest number of committed suicides in the world (37/100 thousand) [5]. Looking back at those projects, 20 years later, it is worth mentioning that they did reach their goal. The incidence of schizophrenia dropped to 7/100 000, which is a good indicator of the treatment efficiency [6].

### **Aim**

The aim of the paper is to acquaint readers with the history of the development of ODA in Scandinavian countries. Its theoretical foundations and limits of application will be discussed. Moreover, the authors' comment on the possible implementation of ODA in the Polish mental health structures (enriched by feedback from trainees) will be provided. Lastly, the authors will demonstrate a correlation between ODA and Polish National Mental Health Programme related to community psychiatry.

### **The search for optimal therapeutic effects**

Yrjö O. Alanen et al. set the direction of the future treatment protocol through conducting a survey in the Psychiatric Clinic at the Turku University in 1960s. The researchers tried to optimise the treatment of schizophrenia by concentrating on psychotherapy. They wanted the treatment model to be available in the public

health sector. The catamnestic study was carried out by collecting data on patients at various stages of the implementation of the method. The selected patients were between 16 and 45 years old, lived in Turku, and were admitted to the psychiatric ward for the first time due to a manifestation of acute psychosis [2]. A standardised research protocol was used in order to compare the gathered data [2]. As a result of the implemented changes, psychiatric units involved in the project turned into therapeutic communities. Primarily, researchers noted better outcomes among patients who underwent individual psychotherapy. Later, in the 5-year follow-up studies, it became clear that the presence of even one empathetic family member significantly improved long-lasting effects [7]. This called for a wider, systematic-oriented training. In 1979, the Finnish Mental Health Association organised the first three-year family therapy course in Turku and in Helsinki [2]. Afterwards, whenever a patient was hospitalised, his/her treatment began with family-oriented meetings. The meetings played an informative (the assessment of the psychotic symptoms and the circumstances leading to the admission to the clinic), diagnostic (the assessment of the therapeutic needs of the family network) and therapeutic (support given to the patient and his network) role [2, 8]. Alanen noticed that families were eager to collaborate with professionals during the first episode of psychosis [2], which substantially improved the process of recovery. As a result of family interventions, psychotic symptoms were remarkably reduced in the assessed prognostic variables (one clinical and two social indicators were chosen) as was the duration of hospitalisation [2]. More patients remained at work and fewer ended up receiving disability allowance. There was a noticeable decrease in the duration of hospitalisation, which fell from 272 to 132 days when therapeutic family meetings were introduced [2]. Scientists distinguished several variables influencing a good prognosis for the patient suffering from the so-called “typical schizophrenia”. The most important variable turned out to be a rare or low-dose use of antipsychotics. A sympathetic relative, gender (female) and long term individual psychotherapy were the other three factors contributing to a positive therapeutic outcome [2]. The working culture of the medical units was reorganised to create a psychotherapeutic attitude towards patients. A new, empathic attitude towards patients necessitated regular team supervision and joint discussion regarding the treatment plans. Since therapeutic relationship was regarded as a core healing element, each patient was assigned a nurse, who was responsible for establishing an empathic bond with him/her [9].

### **Finnish National Schizophrenia Project 1981–1987**

Experience gained through the Turku Project encouraged researchers to initiate a national study, which they named the Finnish National Schizophrenia Project and planned for 1981–1987 [10]. The area included in the study contained one fifth of the Finnish population (around 1 million people). This was an exploratory and developmental programme, whose main aim was to offer optimal psychiatric care

at a national level. The overriding priority was to lower the number of new and old long-term patients hospitalised for over a year by more than 50% and to improve the outpatient mental health service during a 10-year study and its follow-up period. The underlying rationale behind such a strategy was to integrate the applied methods based on psychotherapeutic attitude when attuning to changing needs of the patient [2]. The project comprised patients between 16 and 45 years of age, who were admitted to the psychiatric ward due to a manifestation of acute psychosis and who fulfilled the diagnostic criteria of a schizophrenic disorder and schizophreniform psychosis (based on the Diagnostic and Statistical Manual of Mental Disorders, 3<sup>rd</sup> ed. – DSM-III [11]). Tuori et al. reported that all specific goals not only had been reached, but exceeded the clinicians' expectations [10]. The number of psychiatric beds dropped from 20 to 6 thousands [5]. The patients that remained were transferred to small wards in general hospitals.

By the end of the project, almost all new patients with FEP (First-Episode Psychosis) were treated according to the Need-Adapted Approach. It became evident that starting therapy with therapeutic meetings plays a crucial role in the course of a psychotic crisis. As a result the personnel of the hospital's ambulatory was organised into mobile crisis intervention teams [2]. The key element of the healing process was to act as fast as possible and jointly reflect on the coping strategy. Distinctly, the percentage of patients who had been admitted for observation against their will, and at the end of it agreed to hospitalisation rose from 20% to 50% [2]. Moreover, due to the presence of the patients' network, their motivation to continue the treatment after discharge significantly increased.

The formation of mobile crisis teams covering 50% of the Finnish territory is regarded as a milestone in introducing the principles of NAA into the Finnish mental health care [5, 10, 12]. The idea of intervention teams was implemented in the other Scandinavian countries shortly afterwards [13] where the Johan Cullberg's Parachute Project developed most rapidly [4, 8].

As a consequence of the incessant practice of NAA and constant pursuit of the FNISP goals, the number of professionals in mental health care steadily rose (from 2.5 to 5.1 workers per 10 thousand inhabitants) [10]. The FNISP created 5 general rules of the Need-Adapted Approach [8, 14]: (1) immediate intervention; (2) formulation of a meticulous therapeutic plan, including the changing needs of the patient; (3) a psychotherapeutic attitude towards service users at all stages; (4) integration of various therapeutic perspectives (attitude and/or rather than or/or); (5) necessity of psychological continuity of treatment (professionals are responsible for the patient at different stages of treatment). Summarising their experience, the Finnish scientists suggested regularly monitoring the treatment process and its outcomes [8]. Inspired by the FNISP's results, in Western Lapland, a group of researchers under the leadership of J. Aaltonen ran another project called the Acute Psychosis Integrated Treatment (API), where the work from the previous project was continued [1].

### **Years 1988-1991 – laying new foundations for Finnish Mental Health Care**

A new law on mental health at the beginning of the 1990s decentralised health care, forming 22 psychiatric districts and shifting the responsibility to municipalities. State funds given on a per capita basis were given to local authorities and were spent according to their population's needs. At a national level, new regulations enhancing a stronger integration between institutions, mainly concerning Mental Health Care and Social Welfare systems, were adopted. This legislation strengthened the cooperation between the public and private sector [5].

In order to achieve a “wide-spectrum intervention impact” [15], the majority of mental health professionals were trained. Their education consisted of a one-year introductory training followed by a three-year tuition in systematic family therapy, sensitising the participants on issues of family relationships and the consequent importance of home visits. Participants were encouraged to continue their professional development through individual psychotherapy. After completing the education programme, all the participants received certified psychotherapeutic qualifications. The core element in speeding up the transformation in mental care was collaboration of local MDs working as general practitioners with mental health professionals [15]. They were able to guide the patient, often became engaged in the therapeutic process and frequently invited mobile crisis teams to their offices to seek the most appropriate solution to the patient's problems. The tuition programme lasted from 1989 until 1998. When a sufficient number of mental health workers received proper training, a new project called Acute Psychosis Integrated Treatment (API) was implemented in the period 1992–1993. In the following years, between 1994 and 1998, follow-up studies were conducted to analyse the outcomes of the changes. Meanwhile, in Western Lapland, the method was still applied and developed, and became known as the Open Dialogue Approach (ODA).

### **Acute Psychosis Integrated Treatment (API) 1992–1998**

The API Project was implemented in 6 psychiatric centres covering an area of nearly 600 thousand inhabitants. The programme ran under the Direction of the National Research and Development Centre for Welfare and Health (STAKES) in partnership with the Universities of Jyväskylä and Turku [1]. The outcomes of the ODA treatment were juxtaposed with the control group treated according to the existing pharmacotherapeutic standards (Treatment As Usual – TAU). The main goal of the API Project was to analyse whether the NAA could be used in centres with a different psychiatric treatment culture. The second aim was to determine how long the introduction of antipsychotic medicaments might be postponed. The research protocol consisted of a three-week neuroleptic drug-use delay, although benzodiazepines were prescribed if necessary. Throughout this period, psychosocial interventions intensified, network meetings were held and the general focus was to follow NAA principles [1].

### **Gaining experience after 1998**

Due to the above described modifications, Alanen et al. pointed out a significant reduction in the duration of patient hospitalisation from circa 100 days at the beginning of the 1980s [16] to on average 30 days in Western Lapland (of which 55% lasted less than 10 days) compared to 49 days in the rest of Finland [15]. The shortening of the hospitalisation period was not associated with more frequent hospital stays, as may be hypothesised. Probably this was due to greater efficiency of social networks that have been able to bear the burden of occurring mental disorders. Schizophrenia was diagnosed less frequently, even though the prevalence of schizophrenic psychosis did not alter [15]. The DSM-III chronicity criteria (presence of the illness for at least 6 months), which were a prerequisite for the diagnosis of schizophrenia at the onset of the disease, were met less often [11]. It was concluded that ODA did not prevent the occurrence of psychosis, but that when patients were treated according to the programme, they were excluded from social life less often. These results were consistent in the long-term [15, 17].

Between 1998 and 2008, ODA was transplanted to the Norwegian culture with the cooperation of the University of Agder as well as Sørlandet hospital [13]. It was noticed that the new innovative practice fitted well with what was described by Haynes et al. as evidence based practice decision making [18]. The Open Dialogue method was used within various contexts (educational, academic and medical). Its application provoked discussion regarding what should be included in the professional field of interest among mental health care workers: psychotic crisis along with polyphony versus diagnosing and concentrating on the symptoms [13]. Polyphony appears when each person at the network meeting expresses his/her opinion about the reason for the gathering. Scandinavians deepened the notion of polyphony to the concept of attunement to the patient's experiences, where the therapists tended to accept what had been said [19]. In such situations, dialogue was generated according to the fundamental principle that "there is nothing worse than not being noticed" [20]. The Norwegian researchers summarised their 10-year implementation period with a finding that choosing the most appropriate treatment path played a key role in the patient recovery, while ODA meetings were a fruitful way of dealing with obstacles linked to overcoming a crisis. Johan Cullberg, the head of the Swedish Parachute Project, added that intensifying psychosocial processes resulted in shorter hospitalisations and lower doses of antipsychotic drugs (in a five-year follow-up study, only 29% of ODA patients were treated with neuroleptics, and 76% returned to their job or studies [1, 4]).

### **Open Dialogue Approach nowadays**

Therapy in ODA is based on therapeutic meetings where the patient is present with his/her network. The conversation is lead by a moderator, who is a member of

the crisis team. He/she is accompanied by a reflecting team (RT) [21]. Its theoretical foundation and examples of reflecting processes application readers may encounter in the scientific literature [22] or in author's subsequent publications.

Social constructivism postulates that the cause of a psychotic disorder, be it a problem or a psychological reason, is of a subjective nature. Therefore, it may be perceived differently by each network member. As a result of an interaction between the participants of the therapeutic meeting, this psychological reason may be named and described. Consequently, it appears as a social construct (an interpretation of an event discussed thoroughly and accepted by the network). Each participant speaks for himself/herself while being listened to by others. Each voice is answered and, little by little, the developing dialogicity enables to transform the stigmatising and impoverishing language of diagnosis or psychopathology to a more restorative one of hope and empowerment [23]. It is worth noticing that dialogical practices do not replace the psychiatrist's responsibility for the patient in terms of risk assessment and good medical practices.

OD benefits from systematic family therapy using circular questioning, reflecting processes or positive empowerment [24]. These tools are used to discover a new language through new words that might better portray an alternative narrative. The network plays an active part in the patient's recovery process [25], which eases communication among its members. Better "soft skills" significantly improve collaboration between the patient and the professionals and, most importantly, act as a factor preventing future illness relapses or exacerbations [15].

Based on the collected data and study results of the projects, Finnish investigators formulated 7 assumptions of the OD treatment [15]: (1) family network is put in the centre of therapeutic activities. Mobile crisis teams are formed, and they are responsible for the organisation of the first meeting, preferably within 24h of receiving notification of such a need. (2) The people closest to the patient are invited to the network meeting. Usually these are family members, but they can include any persons important to the patient. (3) The treatment should be need-based using the most appropriate therapeutic perspective in the given circumstances. (4) The mental health worker who first receives the patient becomes immediately responsible for the treatment process regardless of its duration or place of treatment. (5) Psychological continuity of the treatment is a must. (6) The crisis team should focus on building a sense of safety and trust and unconditional acceptance of uncertainty caused by the crisis within the network. (7) Dialogicity should be encouraged, where the patient's empowerment, and not his/her psychiatric symptoms, is discussed. The ultimate crisis team goal is to develop new wording that can illustrate difficult experiences and give a new understanding of the psychiatric crisis [17]. In ODA, pharmacotherapy loses its leading role in favour of psychosocial activities. A complete system of professional training in ODA and team supervision has been built in Finland. Rehabilitation methods that reintroduced patients in recovery to active social life have been developed. Both mental health professionals and patients gave positive feedback to the systematic change in psychiatric care [8].

In Poland, in October 2014, two first to date ODA training courses (8 two-day sessions) were held in Wrocław and Warsaw and further ones have been planned. The training sessions were organised by the Polish Institute of Open Dialogue for mental health professionals (MDs, psychologists, nurses, therapists and social workers). Before the third, fifth and eighth session, the trainees were asked to complete a questionnaire created by the authors aimed at assessing the quality of the course. The questionnaire was based on Kirkpatrick's model of four levels (reaction, competence, application, results). Participants were also encouraged to provide a written feedback on the course. Those who commented on the programme mentioned their inner change from a directive way of dealing with clients to a more empathetic one, an increased sensitivity to non-verbal signs, and better handling of uncertainty in therapeutic situations. They declared themselves ready to assist their clients. Tyszkowska et al. [26] highlight that in the case of schizophrenia, there seems to be a revival of the empowerment and recovery concept, which leads to a transition of the patient's passive attitude towards a more positive one, where he/she actively seeks solutions. Libman-Sokołowska and Nasierowski [27] cite Noiseaux and Ricard, and stress the need for "hope arousal" in patients as it is a driving force in recovery. Sosnowska et al. [28] discuss the relational aspect of work in the field of community psychiatry, where long-term engagement with the patient should be anticipated. This type of relationship goes beyond the standard treatment protocol and makes the worker a participant in the life of the patient. Involvement, shared decision making, focusing on the resources or giving hope, are core elements of ODA.

The authors are cautious about assessing the effectiveness of ODA. There is an apparent lack of well planned, methodically indubitable, prospective surveys investigating the results of the applied methods in various patient groups. In the long term, its effectiveness needs to be measured taking into account the specificity of the Polish mental health care system, especially its funding.

Referring to the results obtained by Finnish researchers Cechnicki et al. [29] state that the main limitation of the present scientific literature is lack of methodological correctness. Critics argue that the number of observed patients diagnosed with schizophrenia is far too small to extrapolate treatment outcomes in a larger population [30]. For this reason, their surveys possess only casuistic value. Besides, where larger groups of patients were taken into consideration, the results did not differ greatly from what is presented in literature [29, 31]. There is a risk that apart from ODA, patients benefited from other forms of treatment (including more biologically oriented mental health care). The above mentioned ambiguities could be resolved if planned, comparative studies were carried out. Scientists from the Krakow Schizophrenia Research Group indicate that the community psychiatry mobile teams should be thoroughly investigated in terms of their effectiveness. They explain that even though ODA is not a revolutionary concept in psychiatry, it may be regarded as a worthwhile organisational model for the Polish psychiatry community, while fulfilling the postulates of the Polish National Mental Health Programme [29]. ODA concentrates on activities in the

patient's natural setting (the postulate concerning the application of multidisciplinary team intervention that integrates all other forms of treatment [32]), engaging his/her network (postulate of mental health promotion and education [32]) trying to meet the patient's needs (postulate of professional stimulation [32]). The recommendation that more research and development in the field of mental health is needed [32] could be followed through cross-sectional and long-term comparative analyses of the results obtained by mental health centres that operate under ODA.

### **Polish perspective on ODA**

In Poland, a humanistic attitude towards psychiatric patients evolved due to the works of Antoni Kepiński. The philosopher Tadeusz Gadacz named him a “dialogical thinker” [33]. Empathetic listening, special sensitivity to nonverbal language along with a willingness to track how the conversation may affect the understanding of the patient enabled, what Kepiński called “getting attuned” with the patient. It was something that he defined as “proper psychotherapeutic process”. His stance was very close to philosophical concepts of the phenomenology of an encounter with another person, which was widely discussed and investigated by Józef Tischner [34]. A therapeutic attitude in a conversation with the patient is continued by numerous therapists and researchers. De Barbaro assumes that what happens during a conversation between the doctor and patient is the very essence of dialogue and should obey dialogical rules. The art of a skilful conversation should be understood as a way of “negotiating the meaning”. At this point, it becomes something more than a mere opportunity to provide the patient with the doctor's prescription. It turns into a tool that serves as an “opening angle” through which the patient talks about himself [35]. The dialogue gains therapeutic value and eliminates the “stigmatising curse” embodied in the psychiatric diagnosis. Researchers from Wciórka's group from the Warsaw Institute of Psychiatry and Neurology [36] and those from Krakow research centres [37] have investigated the meaning of the dialogue between the patient and the people closest to him/her, treatment taking place in the patient's own environment and the issue of mental illness as a source of stigmatisation and suffering. Thanks to their contribution, the idea of community-based treatment with a strong emphasis on home treatment and keeping the patient professionally active was introduced into the Polish National Mental Health Programme. Social activity is perceived by investigators as the “best rehabilitation method” [38]. The dialogue between professionals, patients and their families sheds anew, revelatory light on the essence of recovery. There is an urgent need to utilise methods other than pharmacological intervention. Empathetic support given to the patient at difficult times brings the mental professionals closer to “shared decision making” which seems to be most universal in medical practice [39].

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