Communication – a culture of open dialogue

Val Jackson and Alex Perry

Val Jackson is a Systemic Psychotherapist and Dr Alex Perry is Clinical Psychologist, both at the Aspire, Community Links, Leeds, UK.

Abstract

Purpose – *Open dialogue (OD) is an innovative approach to mental health crises based on close collaboration between services and an individual's family and social network. The approach was originally designed by Jaakko Seikkula and his colleagues in Tornio, Finland and is now being developed in many countries around the world, in particular Denmark, Germany, Norway and the USA. OD describes both a way of being with families and also a way of organising services aimed at maximising communication and connection. The purpose of this paper is to describe the principles of OD, it's development in Finland and here in the UK.*

Design/methodology/approach – *This paper is a description of the principles and outcomes of OD as practised in Western Finland. It also describes the recent developments in the UK using the approach.*

Findings – *This paper is descriptive of the model and is not of a research project.*

Originality/value – *Whilst care must be taken in assuming that these remarkable results are transferable to the UK, other countries and several Mental Health trusts in England are actively engaged with developing an OD approach.*

Keywords *Psychiatric patients, Psychosis, Training, Dialogical approach, Peer workers, Trial*

Paper type *Conceptual paper*

> For the word (and, consequently, for a human being) there is nothing more terrible than a lack of response (Bakhtin, 1975).

Introduction

Open dialogue (OD) is an innovative approach to mental health crises based on close collaboration between services and an individual's family and social network. The approach was originally designed by Jaakko Seikkula and his colleagues in Tornio, Finland and is now being developed in many countries around the world, in particular Denmark, Germany, Norway and the USA. OD describes both a way of being with families and also a way of organising services aimed at maximising communication and connection. This paper describes the principles of OD, its development in Finland and here in the UK.

The OD approach takes the view that all psychotic behaviour is a form of communication for experiences that do not yet have words. Hallucinations, unusual ideas and confused states of mind are understood as metaphors for real events. Seikkula (2014) sees longstanding psychotic behaviour as more an outcome of poor treatment because treatment[1] starts too late and a "non adequate understanding of the problem leads to a wrong response". Psychotic behaviour becomes embedded as a coping strategy that in turn invites responses from others that reinforce an identity of madness. In addition the medicalisation of the behaviour takes responsibility away from the those who are most involved and again reinforces a narrow based understanding of the problem.

Why open dialogue?

The evidence for OD comes from the Tornio project in Western Lapland (Seikkula, 2005, 2011; Aaltonen, 2011). It has been operating there as the only treatment approach for all mental health crises for over 30 years. The outcome data they have so far is from a number of naturalistic studies, with no control group other than the mental health services in the rest of Finland. Whilst limitations in the design of these studies necessitate caution when generalising to other populations and hypothesising about the precise active ingredients, it must be noted nonetheless that the outcomes they have achieved are startling. A short duration of untreated psychosis is seen as an indication for a good prognosis, and this has been reduced to three weeks (the average in the UK lies somewhere between three and 12 months, Dominguez *et al.*, 2013). The occurrence of the diagnosis of schizophrenia has reduced from 32 in 100,000 to two or less. The Tornio project now has the lowest levels of hospitalisation and use of neuroleptic medication with psychosis in Finland and perhaps the western world. In addition, 84 per cent of clients remain in employment, actively seeking employment or studying. These findings cannot simply be due to the rural location, the level of resources or some factor specific to Finnish culture because the outcomes in other similar parts of Finland are broadly equivalent to those found in the rest of Europe. This evidence, plus the testimony of practitioners all over the world who have tried the approach, has been deemed strong enough to form the basis of trials in the UK.

Outcomes

(Aaltonen *et al*., 2011; Seikkula *et al.*, 2011):

- DUP declined to three weeks;
- about 1/3 used antipsychotic drugs;
- in total, 84 per cent returned to full employment; and
- few new schizophrenia patients: annual incidence declined from 33 (1985) to 2-3 /100,000 (2005).

A primary attraction of the OD approach for professionals around the world is its potential as a more compassionate and emancipatory approach to mental distress. Since the time of William Tuke (Bewley, 2008), concerns have been raised about the harm that can be done if we impose an overly narrow/individualistic/biological understanding of distress upon those who are most vulnerable. Despite massive investment over many years in finding cures for mental ill-health, the problem seems to be worsening and our outcomes are no better (and sometimes worse) than those achieved in many developing countries with next to no resources (Whitaker, 2010) . There is a groundswell of activism (from the service-user movement, practitioners and academics alike) shouting that “enough is enough” and calling for a fundamental paradigm shift in our response to misery, fear and confusion.

In the last ten years, there has been increasing evidence demonstrating that long-term use of neuroleptic medication has a significant negative health impact (Whitaker, 2010; Shires, 2011; Moncreiff, 2013) and may in some circumstances worsen an individual’s sensitivity to future psychotic relapse (Whittaker, 2010). Whilst medication can be part of an OD approach, the decision to medicate is usually postponed for a short time to allow for careful discussion of the pros and cons and for a collaborative decision to be made. Given the potential long-term consequences of treatment decisions made at the point of crisis, it is clearly of paramount importance to ensure that these decisions are made in genuine collaboration with service users and their families.

The development of OD in Finland

In the 1980s there was unease regarding the outcomes for those with a diagnosis of schizophrenia so the Finnish National Schizophrenia Project (Alanen, 1997; Salokangas *et al.*, 1991) was established to improve the care for those with serious mental health problems. Alanen

and his colleagues in Southern Finland developed the need-adapted approach, based on rapid early intervention, the planning of treatment to meet the changing and case-specific needs of each patient and family, and the adoption of a therapeutic attitude throughout. Treatment was seen as a continuous process, involving the integration of different therapeutic methods with a move away from individual psychotherapy towards a family approach. There was constant monitoring of progress and outcomes (Alanen *et al.*, 1991; Alanen, 1997; Aaltonen *et al.*, 2011; Seikkula *et al.*, 2003). On the basis of this the OD approach was developed in Finnish Western Lapland, operating within the need-adapted framework. The initial idea behind this development was to offer psychotherapeutic treatment for all patients within their own personal support systems. This was done by generating dialogical communication within the treatment system, and involving mobile crisis intervention teams, patients and their social networks in joint meetings (Seikkula *et al.*, 2003).

As the OD approach was developed, all the mental health outpatient clinics and the 30 bed Keropudas hospital in Tornio (Pop. 72,000) set up case-specific mobile crisis intervention teams. In principle, all clinical staff members could be called upon to participate in these teams. Therefore, the inpatient and outpatient staff (about 100 professionals) participated in a three year training program in either family therapy or some other form of psychotherapy. The same approach is offered to everyone in a mental health crisis regardless of the diagnosis.

The following seven principles were identified as key to the success of OD, as Seikkula and his colleagues undertook naturalistic research on the outcomes of the client population (Seikkula *et al.*, 2003, 2006a).

The seven principles:

- immediate help;
- social network perspective;
- flexibility and mobility;
- responsibility;
- psychological continuity;
- tolerance of uncertainty; and
- dialogism.

Immediate help

> "A common observation seems to be that patients experience reaching something that is unseen by the rest of their family".

The first meeting with the referred client, their social network and any involved agencies is arranged within 48 hours of the first contact. This is seen as a window of opportunity for dialogue that may be lost once the crisis passes. The aim is to establish safety and prevent hospitalisation, so there are intensive meetings during the first two weeks, including out of hours support. All are invited to participate from the outset.

Social network perspective

> "The problem becomes dis-solved only if those that have defined it as a problem no longer communicate it as such".

A key feature of the approach is that the referred client and their social network are encouraged to attend a series of "network meetings". These meetings can occur with a high degree of frequency (potentially every day if the level of distress is high), especially over the first few weeks of contact with services. All those who have concerns about the situation (family, friends, professionals) are invited to the network meetings. The aim of the meetings is to allow all participants to

express their understanding of the situation and to promote meaningful dialogue between them. All discussions about "the problem" and possible resolutions take place in the context of the network meeting.

Flexibility and mobility

The response is need-adapted to fit the special and changing needs of every client and their social network. The meeting place should be jointly selected but there is a sense that meeting in the client's home can often mean that the family have better access to the resources that can help them.

Network meetings are convened by a core group of three professionals from the service, with input from other professionals (psychiatrist, psychological therapist, employment worker, etc.) as required. This core group of professionals is required both to facilitate the "reflecting team" discussions in the meeting and also to provide a certain degree of flexibility (e.g. if one member is unable to attend on a particular day) whilst maintaining continuity for the family.

Responsibility

> "It would no longer be possible to answer a request for help by saying "this hasn't got anything to do with us, please contact the other clinic".

Whichever professional makes the first contact takes responsibility for organising the first meeting and inviting the team. The person contacting the professional may be the patient her/himself, her/his family members, a referring practitioner or other agency.

Psychological continuity

In the OD approach, a core group of professionals endeavours to maintain consistent contact with the family during the life of the problem, with as few changes to key personnel as possible. The priority is for the family to feel connected throughout their pathway through services, including during contact with crisis or inpatient services. Multi-agency meetings are organised whenever required and may include the police, or addiction services, etc. These services are invited to join the meetings rather than clients and families being referred on to them.

Psychological continuity also refers to the integration of different therapeutic methods into a joint treatment process, so that methods do not compete with each other but support each other. For example, individual therapy may be recommended but the therapist will be invited into the network meetings as required or may become a member of the treatment team. As almost all staff are trained family or psychotherapists continuity is relatively easy to achieve.

Tolerance of uncertainty

Increasing a sense of safety

> "For the words to be found, the feelings have to be endured".

When responding to a family who may be in crisis, the first task for professionals is to ensure a basic level of safety. During the early period of contact, where no one yet knows the most useful course of action, the aim is to prevent inappropriate decision making before reaching a better understanding of the situation. The client and their social network are closely involved in the process, thereby mobilising their psychological resources and increasing the sense of agency over their lives. Frequent network meetings take place in the first two weeks, until either a sense of safety is reached for all concerned or the client may become an in-patient. In the latter situation, the ward staff would become part of the network meetings, ensuring a continuity of care.

Generating a space for all to be heard

Everyone present in the meetings is guaranteed a voice, including the person's psychotic experiences (e.g. voices and visions) and individual members of the staff team. Other people who

are unable to attend may participate via phone. It is important that the professionals discuss their personal thoughts about the situation, recognising resilience and determination in individuals as well as concerns about safety. This is usually achieved using a reflecting team, whereby the professionals will turn towards each other within the meeting to offer reflections on the process, allowing the client and his or her network to listen. The reflections are not interpretations, but offered as comments on the situation. E.g. "I was wondering what Dad was thinking when David talked about the anger he feels. It made me feel a bit concerned about what might happen when we leave".

Tolerating contradictory perspectives

Network members are encouraged to listen to each other, and the staff team also share their views which may be contradictory. This helps develop a multi storied perspective to the difficulties, where alternate views are actively encouraged to establish a fuller picture of the nature of the problem and the possible way forward. Such openness to contradictory views without trying to force one particular view or to prematurely reach a consensus is likely to cause anxiety for anyone present who feels that their view is being threatened in some way.

This approach may well be a striking departure from the standard approach of UK mental health services. All too often we have a tendency to present a "united front" to clients and their families, where differences of opinion are ironed out in separate "professionals meetings" to which clients are not invited.

Dialogism

> The crisis becomes an opportunity to generate new stories, in which the experiences emerging in the form of symptoms are clothed in words.

OD uses the terms "dialogism" or "dialogical approach" to describe the way of interacting in the network meetings. The key element is that staff listen and respond to the words spoken, often reflecting them back verbatim, rather than offering an interpretation of meaning or trying to present an "expert" opinion. Psychotic experiences are seen as expressions of something for which there are no words. It is therefore the task of those present in the network meeting to discuss and explore with each other different understandings of the situation that concerns them. This hopefully leads to them finding adequate words that in turn reduce distress and psychotic expressions.

This degree of caution with regard to imposing any pre-determined ideas or agenda may directly contradict many traditional notions of assessment, formulation and diagnosis. Terms such as these are specifically avoided because they can imply that the professional holds the expertise and must simply gather the relevant information. The core activities of making sense of the situation and establishing a workable plan still occur, but they are done more slowly and collaboratively with the network as a whole.

Seikkula and Olson have now developed a guide for dialogical practice (the Key Elements of Dialogic Practice) available at: www.dialogicpractice.net/

What's happening in the UK?

Until recently OD was a way of working that many talked about here in the UK, but none thought it possible in our complex mental health services. However, a few determined individuals have taken a step towards its introduction into mental health services.

A major project involving four trusts is currently in progress, with 50 staff undergoing peer supported OD, network and relational skills training (Jackson, in press). Accreditation as a Foundation course in Family Therapy and Systemic Practice will be applied for. After the training each trust will participate in an randomised controlled trial comparing the OD approach with treatment as usual. A key element of this training is the involvement of peer workers, people who have lived experience. This element is lacking in Finland, but a New York project (Parachute) is successfully integrating IPS, Intentional Peer Support. Dr Russell Razzaque and the

NE London Foundation Trust are leading the UK trial and results should be available in three or four years.

In addition a three year course in OD will also commence shortly. This will be London based and is independently run by Nick Putman, a psychotherapist and OD practitioner, trained in Massachusetts with Mary Olson, the director of the Institute of Dialogic Practice.

Staff from Finland and the USA will be involved in teaching on both courses.

In other areas around the UK there is much interest in the approach with services adopting new ways of working within the framework of treatment as usual (Burbach, in press).

The early intervention in psychosis service (Jackson, in press) in Leeds is undertaking a small trial with two families, offering them network meetings within 24-48 hours of the crisis, and up to six meetings within the first six weeks. This is ongoing with the aim of assessing the feasibility of further implementation rather than demonstrating improved outcomes. Without extra resources suggestions for service change along OD lines are being debated and the authors can be contacted for further details if required.

Conclusion

Whilst OD was an approach that "just made sense" when Jaakko Seikkula first started to spread the word many have been sceptical that it was transferable from the small community of Tornio with a population of 70,000. However, it is now gaining ground in Europe and the USA, and the English speaking world has had the privilege of seeing Mackler's (2012) film that brought the approach into our living rooms. Simultaneously Whitaker (2010), Davis (2013), Moncrieff (2013) and others have raised the awareness of the dangers of being overwhelmed by the DSM and the pharmaceutical industry. However, OD easily engages with both psychology and psychiatry in the current debate on psychosis (Cooke, 2014; Langford *et al.*, 2014), recognising that both have a significant part to play. With two major projects in the UK taking place the possibility of an ethical and humane approach to mental health problems is becoming a reality, one that may not be identical to the Finnish model but one that listens to and acknowledges the experiences of our friends, families and others in our lives without searching immediately for a diagnostic entity, but one that recognises the traumas of life.

Note

1. The Finnish translation of the word treatment relates more to "care" whilst in the UK it is frequently understood as medication.

References

Aaltonen, J., Seikkula, J. and Lehtinen, K. (2011), "The comprehensive open-dialogue approach in Western Lapland: 1. The incidence of non-affective psychosis and prodromal states", *Psychosis: Psychological, Social and Integrative Approaches*, Vol. 3 No. 3, pp. 179-91.

Alanen, Y. (1997), *Schizophrenia. Its Origins and Need-Adapted-Treatment*, Karnac, London.

Alanen, Y., Lehtinen, K., Räkköläinen, V. and Aaltonen, J. (1991), "Need-adapted treatment of new schizophrenic patients: experiences and results of the Turku project", *Acta Psychiatrica Scandinavica*, Vol. 83 No. 5, pp. 363-72.

Bewley, T. (2008), *Madness to Mental Illness: A History of the Royal College of Psychiatrists*, The Royal College of Psychiatrists, London.

Burbach, F., Sheldrake, C. and Rapsey, E. (2015), "Open dialogue in somerset?", *Context*, Association of Family Therapy and Systemic Practice.

Cooke, A. (Ed.) (2014), *Understanding Psychosis and Schizophrenia*, Division of Clinical Psychology, British Psychological Society, available at: www.bps.org.uk (accessed 13 March 2015).

Davies, J. (2013), *Cracked: Why Psychiatry is Doing More Harm Than Good*, Icon books ltd, London.

Dominguez, M., Fisher, H., Major, B., Chisholm, B., Rahaman, N., Joyce, J., Woolley, J., Lawrence, J., Hinton, M., Marlowe, K., Aitchison, K., Johnson, S. and Hodes, M. (2013), "Duration of untreated psychosis in adolescents: ethnic differences and clinical profiles", *Schizophrenia Research*, Vol. 150 Nos 2-3, pp. 526-32.

Jackson, V. (2015), "Getting on with it", *Context*, Association of Family Therapy and Systemic Practice Wiley-Blackwell, Oxford (in press).

Langford, A., Huda, S. and Laws, K. (2014), "Understanding psychosis and schizophrenia; a critique", available at: www.thementalelf.net and Twitter #UnderstandingPsychosis.

Mackler, D. (2012), "Open dialogue: an alternative Finnish approach to healing psychosis", available at: http://recoveryfromschizophrenia.org/2014/04/daniel-macklers-films-are-now-free-on-youtube/ (accessed 13 March 2015).

Moncrieff, J. (2013), *The Bitterest Pills: The Troubling Story of Antipsychotic Drugs*, Palgrave Macmillan, Basingstoke.

Salokangas, R., Stengård, E. and Räkköläinen, V. (1991), "English summary – treatment and prognosis of new schizophrenic patients: a five-year follow up", NSP-Project V, The Foundation for Psychiatric Research in Finland, *Psychiatria Fennica*, Reports No. 94, Helsinki.

Seikkula, J. (2011), "Becoming dialogical: psychotherapy or a way of life?", *The Australian and New Zealand Journal of Family Therapy*, Vol. 32 No. 3, pp. 179-93.

Seikkula, J. and Arnkil, T. (2006), *Dialogical Meetings in Social Networks*, Karnac, London.

Seikkula, J. and Arnkil, T. (2014), *Open Dialogues and Anticipations*, Finnish University Print, Tampere.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. and Lehtinen, K. (2006), "Five-year experience of first-episode non affective psychosis in open dialogue approach: treatment principles, follow-up outcomes, and two case analyses", *Psychotherapy Research*, Vol. 16 No. 2, pp. 214-28.

Seikkula, J., Aaltonen, J., Rasinkangas, A., Alakare, B., Holma, J. and Lehtinen, V. (2003), "Open dialogue approach: treatment principles and preliminary results of a 2 year follow up on 1st episode psychosis", *Ethical Human Sciences and Services*, Vol. 5 No. 3, pp. 163-82.

Shires, D. (2011), "HeAL declaration, healthy active lives, first step trust".

Whitaker, R. (2010), *Anatomy of an Epidemic*, Broadway, Paperbacks, New York, NY.

Further reading

Bakhtin, M. (1984), *Problems of Dostojevskij's Poetics. Theory and History of Literature: Vol. 8*, Manchester University Press, Manchester.

Olson, M., Seikkula, J. and Ziedonis, D. (2014), "The key elements of dialogic practice in open dialogue", available at: www.dialogicpractice.net/ (accessed 13 march 2015).

Razzaque, R. (2014), *The NHS Open Dialogue Project*, available at: www.nelft.nhs.uk/mental_health/Open_dialogue/ (accessed 13 march 2015).

About the authors

Val Jackson is a family therapist and has worked in Early Intervention in Psychosis services for nine years and is currently leading an Open Dialogue trial at her place of work in Leeds. She teaches on the Foundation course in Peer Supported Open Dialogue, Network and Relational skills and is the founder of Developing Open Dialogue. Val Jackson is the corresponding author and can be contacted at: valjackson5@aol.com

Dr Alex Perry is a clinical psychologist and colleague of Val Jackson in the Early Intervention in Psychosis services in Leeds. He is also taking a lead in the Open Dialogue trial as described above.