

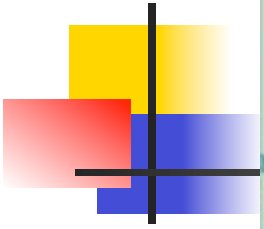
OPEN DIALOGUES: Increasing resources in severe crises



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3th of November 2011 Umass Medical School

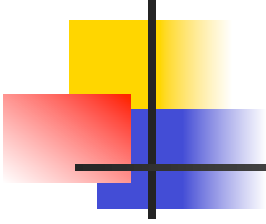
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“For the word (and, consequently, for a human being) there is nothing more terrible than a lack of response”

“Being heard as such is already a dialogic relation” (Bakhtin, 1975)



Challenges for treatment of psychotic problems – early notions

- Clients become not heard – neither the patient nor the family members
- Over-emphasis on inpatient treatment – patients disposed to others' psychotic behavior (J. Cullberg)
- Over-emphasis on medication – may increase the risk for brain function and mortality
- Over-emphasis on pathologizing the problems – resources are not seen



Origins of open dialogue

- Initiated in Finnish Western Lapland since early 1980's
- Need-Adapted approach – Yrjö Alanen
- Integrating systemic family therapy and psychodynamic psychotherapy
- Treatment/therapy meeting 1984
- Systematic analysis of the approach since 1988 – “social action research”
- Systematic family therapy training for the entire staff – since 1989



Steps to Open Dialogue in Western Lapland

- Psychotherapies as methods 1980 – 1984
- 1984 open therapy meetings: good and confusing outcomes
- 1987: First studies of admission to hospital – need for crisis interventions
- 1989: Mobile crisis intervention teams
- 1994 – 1996: Optimal principles - OD



MAIN PRINCIPLES FOR ORGANIZING OPEN DIALOGUES IN SOCIAL NETWORKS

- IMMEDIATE HELP
- SOCIAL NETWORK PERSPECTIVE
- FLEXIBILITY AND MOBILITY
- RESPONSIBILITY
- PSYCHOLOGICAL CONTINUITY
- TOLERANCE OF UNCERTAINTY
- DIALOGISM



IMMEDIATE HELP

- First meeting in 24 hours
- Crisis service for 24 hours
- All participate from the outset
- Psychotic stories are discussed in open dialogue with everyone present
- The patient reaches something of the “not-yet-said”



SOCIAL NETWORK PERSPECTIVE

- Those who define the problem should be included in the treatment process
- A joint discussion and decision on who knows about the problem, who could help, and who should be invited into the treatment meeting
- Family, relatives, friends, fellow workers, and other authorities



FLEXIBILITY AND MOBILITY

- The response is need-adapted to fit the special and changing needs of every patient and their social network
- The place for the meeting is jointly decided
- From institutions to homes, to working places, to schools, to polyclinics etc.



RESPONSIBILITY

- The one who is first contacted is responsible for arranging the first meeting
- The team takes charge of the whole process regardless of the place of the treatment
- All issues are openly discussed between the doctor in charge and the team



PSYCHOLOGICAL CONTINUITY

- An integrated team is formed, including both outpatient and inpatient staff
- Meetings as often as needed
- Meetings for as long period as needed
- The same team both in the hospital and in the outpatient setting
- In the next crisis the core of the same team
- Not referred to another place



TOLERANCE OF UNCERTAINTY

- To build up a scene for a safe enough process
- To promote the psychological resources of the patient and those nearest him/her
- To avoid premature decisions and treatment plans
- To define open



DIALOGICITY

- Emphasis on generating dialogue - not primarily in promoting change in the patient or in the family
- New words and joint language for the experiences, which do not yet have words or language
- Listen to what the people say, not to what they mean
- Accept the other without conditions

DIALOGICITY - GUARANTEEING JOINT HISTORY



- Everyone participates from the outset in the meeting
- All things associated with analyzing the problems, planning the treatment, and decision making are discussed openly and decided while everyone is present



DIALOGICITY - STRUCTURE BY THE CONTEXT

- Meeting can be conducted by one therapist or the entire team can participate in interviewing
- Task for the facilitator(s) is to (1) open the meeting with open ended questions; (2) to guarantee voices are heard; (3) to build up a place for discussions among the professionals; (4) to conclude the meeting with definition of what have we done.



Open dialogues with good and poor outcomes for psychotic crisis/ Jaakko Seikkula, 2002 /Journal of Marital and Family Therapy, 28(3):263 - 274

SUMMARY

	Good outcome	Poor outcome
Interactional dominance by clients	55-57%	10 – 35%
Semantic dominance by clients	50-70%	40 -70%
Symbolic language area in sequences	67 – 80%	0 – 20%
Dialogical dialogue in sequences	60 – 65%	10 – 50%



Variations: Acute Team in Tromsø

- Dr. Magnus Hald and Annrita Gjertzen
- Acute team in connection with the acute ward
- Good strength (n=15/70,000), work from 8 a.m. to 8 p.m. every day, night duty in the ward
- All contacts to acute psychiatry via the team
- Reflective processes as the form of dialogues – one interviews, the other one(s) listening and commenting later on
- Two years training for the staff ("Relation and network education")



Variations: Children and Adolescent Psychiatric Unit in Gällivare, Sweden

- Dr. Eva Kjellberg
- Serves large area with 200,000
- Nearly connected to social care
- After referral always the first meeting together with the family, the referring authority, and relevant others
- Need for further treatment decreased rapidly when the network mobilized
- Reflective processes as the form of dialogue
- Two years training



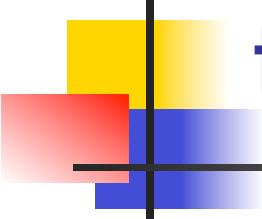
Variations: Home Treatment Teams in Germany

- Dr. Volkmar Aderhold and Nils Greve
- Ambulatory services for acute patients and others in the psychiatric units (population can be e.g. 200,000 to 300,000) (N = 22 teams at the moment)
- Insurance driven practice – specific agreement with insurance companies of a project period – evaluation started
- Two years training



Variations: Open Dialogue acute teams in Denmark

- Jaana Castella
- Several units in Denmark – acute team for crises interventions
- Training programs, often 1 year
- Change in the entire system



Variations: Psychosis/Acute team in Newcastle

- Dr. Alex Reed and Brian Martindale
- Mental Health Trust
- Working for some years



Dialogical practice is effective

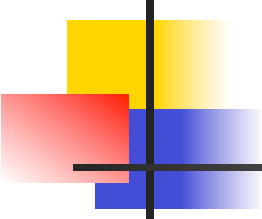
Open Dialogues in Tornio – first psychosis, 5 years follow-up 1992- 1997 (Seikkula et al., 2006):

- - 35% needed antipsychotic drugs
- - 81% no remaining psychotic symptoms
- - 81% returned to full employment

Outcomes stable 2003 – 2005 (Seikkula et al, 2011):

- - DUP decreased to three weeks
- - Few new schizophrenia patients (from 33 to 2/100,000 every year)
- - 84% returned to full employment

COMPARISON OF 5-YEAR FOLLOW-UPS IN WESTERN LAPLAND AND STOCKHOLM

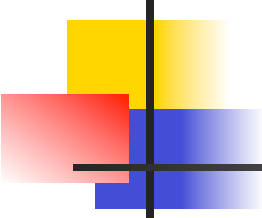


	ODAP Western Lapland 1992-1997 N = 72	Stockholm* 1991-1992 N=71
Diagnosis:		
Schizophrenia	59 %	54 %
Other non-affective psychosis	41 %	46 %
Mean age years		
female	26.5	30
male	27.5	29
Hospitalization		
days/mean	31	110
Neuroleptic used	33 %	93 %
- ongoing	17 %	75 %
GAF at follow-up	66	55
Disability allowance or sick leave	19 %	62 %

- *Svedberg, B., Mesterton, A. & Cullberg, J. (2001). First-episode non-affective psychosis in a total urban population: a 5-year follow-up. Social Psychiatry, 36:332-337.

Dialogues in couple therapy for moderate depression (Seikkula et al 2011)

- "Significant improvement" 79% in depressive symptoms and 61% in general mental health
- More rapid recovery compared to individual Treatment as Usual
- Differences between psychiatric units – better outcome in crisis service oriented Open Dialogue system in Western Lapland



“Love is the life force, the soul, the idea. There is no dialogical relation without love, just as there is no love in isolation. Love is dialogic.”

(Patterson, D. 1988) Literature and spirit: Essay on Bakhtin and his contemporaries, 142)