Open Dialogues with Patients and Their Families in Adult Psychiatry

Jaakko Seikkula Ph.D. Professor of psychotherapy, University of Jyväskylä, Finland
taakko.a.t.seikkula@jyu.fi

Abstract
The open dialogue (OD) family and network approach aims at treating mental health crises in the community. The treatment involves the patient’s social network and starts within 24 hours after contact. Responsibility for the entire treatment process rests with the same team in both inpatient and outpatient settings. The general aim is to generate dialogue with the family to construct words for the experiences that occur when psychotic or other symptoms exist. In Finnish Western Lapland several studies have been conducted about the outcome in the most severe crises. In case of first episode psychosis, 33% in the OD approach had used neuroleptic medication compared to 100% in the treatment as usual at five-year follow-up. Further, 19% were at this point living on a disability after the OD approach, while in treatment as usual more than 60% of psychotic patients were retired. The results illustrate how the emphasis on family therapy in psychiatric care increases the resources of the clients to return to active social life after their crises.

Keywords: generating dialogues, family therapy, psychosis

Sammendrag

Nøkkelord: etablering av dialoger, familieterapi, psykoser

THE CONCEPT OPEN DIALOGUE was first used in 1995 to describe the entire family and social network-centred treatment approach that was first initiated in Finnish Western Lapland. The approach includes two elements: first, open meet-
ings in which all relevant members in the actual situation – including both the social network of the client and the professionals working as a team – participate from the outset to generate new understanding through dialogue; second, the guiding principles for the entire system of psychiatric practice in one geographic catchment area. The main forum for dialogues is the open treatment meeting where all management plans and decisions are made with everyone present.

In Western Lapland in the early '80s we started to follow the experiences within the Need-Adapted approach. In Finland, psychotherapeutic practice has long been a part of public health care and especially important has been the development and research in the Turku Psychiatric Clinic since the 1960s by professor Yrjö Alanen and his team. Starting with individual psychodynamic psychotherapy, the Turku team integrated systemic family therapy into their treatments in the late 1970s and called the approach Need-Adapted Treatment, emphasizing that every treatment process is unique and should be adapted to the varying needs of each patient. To make it possible to find the unique needs of every patient and the family they generated the genuine innovation of the open treatment meeting that we adapted to the clinical work in Western Lapland at Keropudas Hospital in 1984.

The special aspects of the Need-Adapted approach were to focus on: (1) rapid early intervention in every case; (2) treatment planning to meet the changing and case-specific needs of each patient and family by integrating different therapeutic methods in a single treatment process; (3) having a therapeutic attitude as the basic orientation for each staff member in both examination and treatment; (4) seeing treatment as a continuous process; and (5) constantly monitoring treatment progress and outcomes (Alanen, 2009; Alanen et al., 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 doing an accurate diagnosis of the case. By contrast, Need-Adaptiveness focuses on the idea that the ‘right’ diagnosis emerges in joint meetings; and it became clear to us that the process of understanding, that is, arriving at a full and practical understanding in a dialogic manner by all concerned of what has happened, can itself be a very therapeutic process.

Anticipating the psychotherapy research about common factors, the Need-Adapted approach already in the early 1980s was integrating different psychotherapies, instead of choosing one school or approach; for example, just systemic family therapy or individual psychodynamic psychotherapy. In writing
about family therapy in adult psychiatric setting, this element of the approach is relevant for inclusion.

Open dialogues in organizing psychiatric practice

When we in the beginning of the 1980s began to develop the acute psychiatric inpatient system at Keropudas Hospital in Tornio, we had two primary interests. First, we were interested in individual psychotherapy for patients diagnosed with schizophrenia. At that time Keropudas Hospital was occupied by dozens of long-term patients who had been considered ‘incurable’. What was important in the Need-Adapted tradition was the shift to learn how to work with the psychological resources of patients with psychotic problems; finding ways to make use of patients’ own psychological resources in our treatments has proved to be crucial.

When starting to work with the open treatment meetings, we first met successful and unexpected outcomes. At the same time, however, we were faced with confusing experiences, which we could not understand and realized that we needed both more training of the staff and finding ways of analysing the new practice concerning both the content of the processes and the outcomes. Several effectiveness and treatment process evaluations of the open dialogue approach have been completed employing an action research methodology (Aaltonen et al., 1997, 2011; Haarakangas, 1997; Keränen, 1992; Seikkula, 1991, 1994; Seikkula et al., 2003, 2006, 2011). In one of the studies that was conducted during the years 1993–1995 led by Jukka Aaltonen (Aaltonen et al., 2011), we summarized the optimal elements of the approach, in which the main part of the psychiatric crises was taken care of by organizing mobile crisis intervention teams with the first meeting at the patient’s home instead of hospitalization. The main principles of an optimal treatment process were: (1) immediate response; (2) a social network perspective; (3) flexibility and mobility; (4) responsibility; (5) psychological continuity; (6) tolerance of uncertainty; and (7) dialogism. This was the time when we also started to reflect on how to name the new approach and after concluding the main elements of an optimal process of care we proposed to use the concept of Open Dialogues for this approach. “Open” here refers to the idea of always having all meetings open to all the members of the social network of the patient to discuss the treatment. “Dialogue” refers to the main aim of the approach being the generating of new understanding about the life and about the crises by generating dialogue among all the participants in the open meeting. These principles of the open dialogue approach are enlarged upon
below. It is worth noting that these principles came out of research and were not principles planned before and then followed. Later on, more general ideas about good treatment were added. Although most of the studies have focused on the treatment of psychotic problems, they are not diagnosis-specific, but describe an entire network-based treatment that is especially practical for initiating in crisis situations. The mentioned principles will be presented in greater detail in the following.

*Immediate response.* In a crisis it is vital to act immediately, and not, for instance, to wait for the patient with psychosis to become more coherent before a family meeting. It is preferable that the first response be initiated within 24 hours. Therefore, a 24-hour crisis service ought to be set up. One aim of the immediate response is to prevent hospitalization in as many cases as possible. Everyone, including the patient, participates in the very first meetings during the most intense psychotic period. The patients usually seem to be experiencing something important to the family. Although the patient’s comments may sound incomprehensible in the first meetings, after a while it may become apparent that the patient was actually speaking of real incidents in his or her life. Often these incidents include some terrifying issues or a threat that he or she has not been able to articulate before the crisis. Psychotic experiences most often include real incidents and the patient is bringing forth themes that have not previously been spoken about. This is also the case in other forms of difficult behaviour. In extreme anger, or depression, or anxiety, the patient is speaking of previously unspoken themes. In this way, the main person in the crisis, the patient, reaches for something that had not been touched by others in his or her surroundings. The aim of the treatment becomes the expression of these experiences that previously had no words to form into a narrative. During the first couple of days of a crisis, it seems possible to speak of things that are difficult to discuss later. It is as if the window for the extreme experiences only stays open for the first days, and during this period of time the patient is ready to speak for instance about the hallucinations. If the team manages to create a safe enough atmosphere by responding rapidly and listening carefully to all the themes the clients bring up, then important themes may find a space where they can be handled, and the prognosis improves.

*Including the social network.* The patients, their families, and other key members of their social network are always invited to the first meetings to mobilize support for the patient and the family. The other key members may be representatives of other authorities, such as state employment and insurance agencies,
vocational rehabilitation services, fellow workers or the supervisor at the patient’s workplace, neighbours or friends. In the most severe crises, the first notion of a problem often emerges in the definition of those closest to the patients after they note that some forms of behaviour no longer conform to their expectations: for example, if a young member of the family is suspected of using drugs. The young person will seldom see using drugs as a problem, but their parents can be terrified by the first signs of possible drug misuse. From a network perspective, all these individuals should be included in the process. It is helpful to adopt a simple way of deciding who should be invited to meetings. It can be done, for instance, by asking the person who made the contact in the crisis: (1) Who is concerned about the situation or who has been involved? (2) Who could be of help and is able to participate in the first meeting? (3) Who would be the best person to invite them, the one who contacted the services or the treatment team? By doing it this way, the participation of those closest to the patient is suggested as part of an everyday conversation, which decreases any possible suspicion about the invitation. The one who has contacted the services can decide who they do not want to participate in the meetings. The aim is to have the meeting with the family as the very first therapeutic occasion with the clients before going into individual meetings. If the proposal for a joint meeting is done after an individual session with the patient in an official tone, by asking, for instance, “Will you allow us to contact your family and invite them to a meeting?” problems may arise in motivating both the patients and those close to them.

Another factor in deciding about the relevant participants is to find out whether the clients have contacted any other professionals either in the current situation or previously. If the other professionals cannot attend the first meetings, a joint meeting can be arranged later. The people in the client’s social network can be included in many ways. They can be present, or if some of them cannot manage to attend meetings, some member of the network can be given the task of contacting them after the meeting and relaying the absent person’s comments to the next joint meeting. Those present can be asked, for instance, ‘What would Uncle Mark have said if he was present in this conversation? What would your answer be? And what would he say to that?’

Flexibility. Flexibility is guaranteed by adapting the treatment so that it is a response to the specific and changing needs of each patient and his or her family using the therapeutic methods best suited to each family, their specific language and their way of living. The approach and the length of treatment should fit the actual problem instead of applying a generic programme without varia-
tion from case to case. During the first ten to twelve days of a crisis, the need is quite different compared with the need three weeks later. For instance, during the most acute phase it is advisable to possibly have a meeting every day, which will no longer be necessary once the situation has stabilized. In that later period, families generally know how frequently they should be meeting. The best place for the meeting, if the family approves, might be the patient’s home. However, meetings in an emergency department or a psychiatric outpatient clinic are an option, if the family sees this as more suitable. Home meetings seem to prevent unnecessary hospitalizations, since the family’s own resources are more accessible in a home setting (Keränen, 1992; Seikkula, 1991). Families can easily refuse to participate in treatment, if the invitation is made formally or if the professionals follow too rigid ways of working with families. In their approach in Norway, Friis (Friis et al., 2003) with his team in the TIPS project announced that 40% of families of psychotic persons did not participate in the treatment, whereas in Open Dialogue approach 99% of the families participated in the treatment of first episode psychosis (Seikkula et al., 2006). The Need-Adaptive approach seems to suit the Nordic system, in which every psychiatric unit has total responsibility for all clients in its catchment area.

Responsibility. Organizing a crisis service in a catchment area is difficult if all the professionals involved are not committed to providing an immediate response. A good rule of thumb is to follow the principle that whoever is contacted takes responsibility for organizing the first meeting and inviting the team. The one contacting the professional could be, for example, the patient, a family member, a referring practitioner or other authorities, such as family doctor or a school nurse. Organizing an acute team as a part of the services is a good possibility so that all staff members know who to contact to organize an immediate first meeting. This means that it is no longer possible to respond to a request for help by saying, “This has nothing to do with us, please contact the other clinic”. It is important to reassure the family member contacting the service that they have come to the right place and that the service will take care of organizing a meeting. One can say, for instance, “It sounds to me that alcohol misuse may be involved in your son’s problem. Would you allow me to invite someone from the alcohol misuse clinic to join us in the meeting tomorrow?” In the meetings, decisions are made as to who are the ones to best form the team that will be responsible for the treatment. In multi-problem situations, the best team is formed with professionals from different units, for instance, one from social care, one from a psychiatric outpatient clinic and one from the hospital.
The team mobilized for the first meeting should take all the responsibility needed for analyzing the current problem and planning the treatment. Everything needed for an adequate response is available in the room, there is no other authority elsewhere that will know better what to do. This means that all team members should take care of gathering the information they need for the best possible decisions to be made. If the doctor was not able to attend the meetings, this individual should be consulted by phone, and if there is a difference of opinion about certain decisions, a joint meeting is advisable to discuss the choices in the presence of the family. This empowers family members to participate more in the decision-making process.

Guaranteeing psychological continuity. The team takes responsibility for the treatment for as long as needed in both outpatient and inpatient settings so that the very same therapist is in charge of the treatment in both settings by working as a team. This is the best way to guarantee psychological continuity. Forming a multidisciplinary team early increases the possibility of crossing the boundaries of different treatment facilities and preventing people dropping out. In the first meeting it is impossible to know how long the treatment will continue. In some instances, one or two meetings are enough, but in others, intensive treatment for two years may be needed. Problems may occur if the crisis intervention team meets three to five times and then refers the patient to other authorities. In these circumstances, even in the first meetings, there is a risk of too much focus on actions to be taken and not enough on the process of dialogue itself. Representatives of the patient’s social network participate in the treatment meetings for the entire treatment sequence, including when other therapeutic methods are applied. One part of psychological continuity is to integrate different therapeutic methods into a cohesive treatment process where different methods complement each other. For instance, if individual psychotherapy is recommended for the patient, psychological continuity is easily guaranteed by having one of the team members act as the individual psychotherapist. If this is not possible or advisable, the psychotherapist could be invited to one or two joint meetings, in which ideas are generated that can serve as the basis for an individual therapy process. The therapist should be invited every now and then to meetings with the team and the family. Problems may occur if the individual psychotherapist does not want to participate in the joint meetings. This can intensify the family’s suspicion towards the therapy, sometimes affecting the entire treatment process. This is particularly important in the case of children and adolescents.
Tolerating uncertainty. The first task for professionals in a crisis is to increase the safety of the situation, when no one yet knows the reasons for the problem nor what the solutions will be. The aim is to mobilize the psychological resources of the patient and those nearest to him or her to increase the agency in their own life, by generating new stories about their most extreme experiences. This is supported by building up a sense of trust in the joint process. For instance, in psychotic crises, an adequate sense of safety can be generated by meeting every day at least for the first ten to twelve days. After this, longer intervals between the sessions are possible. Usually no detailed therapeutic contract is made in the crisis phase, but instead, at every meeting it is decided if and when the next meeting will take place. In this way, premature conclusions and treatment decisions are avoided. For instance, neuroleptic drugs are not commenced during the first few weeks. This allows for more time to understand the problem and the whole situation. There is also time for spontaneous recovery and, in some cases, the problem can resolve itself. A recommendation for neuroleptic drugs should be discussed in at least three meetings before implementation to clarify whether those present think the drugs are necessary. This approach contrasts with illness-oriented approaches that during the early phase of treatment focus on trying to remove symptoms with drugs. For psychotic patients, these are typically neuroleptics. Psychiatric drugs can affect the intensity of hallucinations, of course, but the risk is that they decrease psychological resources at the same time. Neuroleptic drugs often have a sedative effect that calms psychological activity and thus may be a hindrance to psychological work. The challenge is to create a process that increases safety and encourages personal work. In our study only 33% of acutely psychotic patients used neuroleptics at all during the five-year follow-up period (Seikkula et al., 2006).

Besides the practical aspects of seeing that the family is not left alone with its problems, increasing safety means generating a quality in the therapeutic conversation such that everyone can be heard. Working as a team is one prerequisite in guaranteeing safety in a crisis with loaded emotions. One team member may start to listen more carefully to what the son says when he is saying that he does not have any problems; it is his parents who need the treatment. The other team member may become more interested in the family’s burden of not being successful at stopping his drug misuse. Already in the very first meeting, it is good to reserve some time for reflective discussion among the team in the presence of the family to guarantee the different and often con-
contradictory perspectives to be heard, and consequently every family member having a feeling of being recognized and accepted. If the team members can listen to each other, it may increase the possibility for the family members to listen to each other as well. A situation in which professionals are in a hurry to get to the next meeting and therefore propose a rapid decision is not the best use of the family members’ psychological resources. It would be better to note that important issues have been discussed, but no firm conclusions can be made and thus the situation is defined as open. One way to put it into words might be: “We have now discussed this for about an hour, but we have not reached any firm conclusion of what this is all about or the best option to address it. However, we have discussed very important issues. Why not leave this open and continue tomorrow?” After that, concrete steps should be agreed on before the next meeting to guarantee that family members know what they should do if they need help.

*Dialogicity.* In meetings, the focus is primarily on promoting dialogue and only secondarily on promoting change in the patient or in the family. Dialogue is the forum through which families and patients can acquire more agency in their own lives by discussing the problems (Haarakangas, 1997). A new understanding can be generated in dialogue (Andersen, 1995; Bakhtin, 1984). For a professional, this means eliciting new aspects of being an expert in whom clients can trust. Professionals must become skillful in promoting dialogues through which their specific expert knowledge becomes rooted in the context.

Overall, the starting point for the dialogue in the open treatment meeting is the language of the family, how each family has, in their own language, described the patient’s problem. Everyone present speaks in their own voices. The stance of the therapists is different compared with the traditional one in which it is the therapist who makes the interventions. While many family therapy schools are especially interested in creating specific forms of interviewing, in focusing on generating dialogue, listening and responding responsively becomes more important than the manner of interviewing. Team members can comment on what they hear with each other as a reflective discussion while the family listens (Andersen, 1995).

**Implementation challenges**

Our view of psychiatric and family therapeutic treatment was challenged in the following ways:
• Treatment planning with stable plans was not possible, but every meeting generated a new plan as a process. This process of planning and re-planning the treatment was very helpful.

• We could no longer apply the idea of the therapist as initiating the change in the family system by different family therapy interventions.

• We realized that a family therapeutic approach was possible in a public sector inpatient setting, even though the Milan team had said that a prerequisite for systemic therapy is to stay away from the institution (Selvini-Palazzoli et al., 1978).

• While the guidelines of systemic family therapy by the Milan school or structural therapies seemed not to be the solution, we were ‘forced’ to look for other options. Systemic family therapy focused on seeing the problem or symptoms as a function of the family system. But in generating open dialogue we aimed at having all the different voices being heard, without any idea of whether they had a function in the family system. Thus, the intervention was not to initiate change in family interaction, but to generate new words and narrate new happenings.

Experiences from open dialogue therapy sessions
The meeting takes place in an open forum. All participants sit in a circle in the same room. The team members who have taken the initiative for calling the meeting take charge of opening the dialogue. On some occasions, there is no prior planning regarding who takes charge of the questioning and thus all staff members can participate in interviewing. On other occasions, the team can decide in advance who will conduct the interview if the team members are used to more structured action in the therapeutic sessions. 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 the moment for them. The opening questions could be, for instance, asking how you would like to use this time or asking who would be the best one to start. The team does not plan the themes of the meeting in advance. From the very beginning the task of the clinicians 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 what the client and family members have said. Often this means repeating word for word some part of the utterance and encouraging saying more about the issue.
In a psychotic crisis it may happen that the patient does not want to participate in the meeting or runs out of the meeting room suddenly. The team needs to discuss carefully with the family members whether to continue the meeting. If the family wants to continue a staff member goes after the patient to inform him/her that she or he can return if she or he wants. During this discussion we do not make any other decisions concerning the patient.

Everyone present has the right to comment whenever she or he is willing to do so but comments should not interrupt an ongoing dialogue. 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 about their thoughts in response to what is being said. Most often, in those comments, professionals may repeat word by word a part of the utterance thus verifying the client’s most difficult experiences. In every meeting there is also a need to handle issues that are relevant to the unit and it is advisable to focus on these issues toward the end of the meeting, after family members have spoken about what are the most compelling issues for them. 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 begin 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 the decisions that have been made, and if so, what they were. The length of meetings can vary, but usually ninety minutes is adequate.

As the reader can see, our approach in many respects is resonant with the dialogical, language-based family therapy of Harlene Anderson and Harry Goolishian (1988), which was later developed by Anderson (1997) into collaborative therapy. We also found a resemblance to Tom Andersen’s (1991) work on reflective team dialogues and processes. Interestingly, these approaches developed about the same time, but we only became aware of them later on, which gave us support to move in the direction we had chosen. This open way of working was very enthusiastically received from the beginning, which encouraged us to proceed, but quite rapidly we started to have confusing and unexpected experiences. Later we realized this was a consequence of the patient and family being actively involved in the process of understanding the problem and planning the treatment. We could no longer follow the traditional idea of first
planning and then conducting a treatment approach. Also, we confronted various therapeutic impasse situations, which were negotiated by adapting our interventions to how the family was talking about and living the actual crisis.

In every session with our clients two histories happen. The first is a history generated by our presence as embodied living persons. We adapt ourselves to each other and create a multi-voiced polyphonic experience of the shared incident. Salgado and Hermans (2005) point out that we cannot call this ‘experience’, because experience already presumes psychological meaning that is included by the Other or Otherness in the situation. It is our embodied experience for which manifold meanings emerge, based on the number of participants in the situation. Family sessions as such already include several family members and often two or three therapists. Most of this history takes place without words, but not all. The words that refer to our presence in this conversation often include the most important emotions connected to those voices of our lives that deal with difficult experiences. We may, for example, describe and reflect on our feelings about the specific situation we are talking about.

The second history in the same situation occurs in the stories that living persons tell of their life. Stories always refer to the past; they never can reach the very present moment, since when the word is formulated, and when it becomes heard, the situation in which it was formulated has already passed. Integrating the two aspects of the same moment, it becomes evident what the focus on dialogue can add to a narrative orientation. As Lowe (2005) stated: ‘The conversational style . . . simply follows the conversation, while the narrative and solution-focused styles often attempt to lead it’ (p. 70, my emphasis).

Compared to narrative and solution-focused therapies, in dialogical approaches the therapists’ position becomes different. Therapists are no longer interventionists with some preplanned map for the stories that clients are telling. Instead, their focus is on how to respond to clients’ utterances, as their answers are the generators for mobilizing the client’s own psychological resources (Bakhtin, 1984, p. 127). Respecting the dialogical principle that every utterance calls for a response, team members strive always to answer what is said. Answering does not mean giving an explanation or interpretation but, rather, demonstrating in a therapist’s response that one has noticed what has been said and, when possible, opening up 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 a 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 of what she has said. 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.

The long-term effectiveness of the open dialogues approach

In Western Lapland, the effectiveness of open dialogue has been assessed in follow-up studies for first-episode psychotic patients. Patients diagnosed with schizophrenia were hospitalized significantly less compared with usual treatment, an average of fourteen days/person compared with one hundred and seventeen over a two-year period (Seikkula et al., 2003). Only 33% used neuroleptics during some phase of treatment compared with 100% in the comparison group. Families were actively involved in all cases, having an average of twenty-six meetings over two years. When comparing outcomes, open dialogue patients diagnosed with schizophrenia seem to recover better from their crises. At least one relapse occurred in 71% of the comparison group of patients compared with 24% in the open dialogue group. Only 17% of the open dialogue patients had at least occasional mild symptoms, compared with 50% in the comparison group. As many as 81% had returned to full employment compared with only 43% in the comparison group.

The results with open dialogue patients remained positive at five-year follow-up (Seikkula et al., 2006). When compared with the entire group of non-affective psychotic patients, only 29% of open dialogue patients experienced one or more relapses and 82% of open dialogue patients had no residual psychotic symptoms. Employment status was better than in any other outcome study, with 81% of the open dialogue patients returning to their studies, work or to active job-seeking. When replicating the same design of the study ten years after the preliminary studies, it was found that the outcomes in Western Lapland had stayed about the same (Seikkula et al., 2011). Out of the first episode patients, 84% had returned to full employment in the two years follow-up period. At the same time some interesting changes also had occurred. In all these periods of research, neuroleptic medication was used in about one third of the patients. We may conclude that the open dialogue approach has made pos-
sible to decrease the role of neuroleptic medication in the treatment of psychosis and thus avoid the harmful side-effects of medication and increase the positive outcome. The duration of untreated period of psychosis (DUP) before the start of the treatment had declined to three weeks in Western Lapland. In traditional treatment without acute crises services psychotic symptoms may have been continuing more than one year before the start of the treatment (Larsen et al., 1998). Perhaps in relation to this, the incidence of schizophrenia has declined in Western Lapland from 33 new schizophrenia patients per 100 000 inhabitants in 1985 to two or three in 2005 (Aaltonen et al., 2011; Seikkula et al., 2011).

In the most recent research project, the 20-year follow-ups of the first-episode psychotic patients are analysed (Bergström et al., 2017). The first analyses showed that about one third are using psychosis medication. When comparing to the treatment as usual of psychotic patients in Finland, significant differences emerge in relation to the use of psychosis medication, in the mortality and in the retirement rate. In Western Lapland the number of patients living on a disability allowance is the lowest in Finland (35%) when the rate in the rest of Finland is about twice as high (Kiviniemi, 2014).

Conclusions and reflections
The results show a remarkable change in the prognosis for severe mental health problems. This suggests that the approach to psychiatric crises should change. We are used to thinking of psychosis as a sign of schizophrenia and schizophrenia as a relatively stable state that affects the patient throughout the entire life. For instance, a third of the patients with schizophrenia are said to need ongoing treatment, a third will need intermittent treatment, and a third will fully recover and actively work. In the few long-term follow-up studies of first-time psychotic patients after five years treated by traditional methods, more than a half, often about 60% are said to be living on a disability pension (Lenior et al., 2001; Svedberg et al., 2001). The positive outcomes using the open dialogue approach may indicate that mental health problems no longer need to be a sign of illness but can be viewed as one way of dealing with a crisis and after this crisis, many or most people are capable of returning to their active social life. And given that so few actually need psychosis drugs in treatment of psychosis, we can ask whether our understanding of the underlying problem needs to change. We should re-think the way psychiatric services are organized. Instead of primarily focusing on having control over the symptoms and removing the
symptoms as rapidly as possible, the attention could be on organizing meetings for those involved, including family members and other relevant individuals from the personal social network and from professional networks. It seems to mean that in these meetings we should be more interested in generating dialogues by following what family members are saying than in planning interventions aimed at change in the patient or in the family. If so, the training of professionals should be restructured to include these new aspects: not only to read books about medical interventions, but also to reflect upon the philosophy of our human views and how to generate dialogue and listen to people instead of dominating the therapeutic process.

What is described above sets the context for my personal understanding of psychotherapeutic work. It is not a generalized model, but specifically relates to the development of the project in Western Lapland for dealing with the most severe mental health crises. During the last 20 years I have been involved in developing dialogical practices within many types of contexts and with many types of clients, children, adolescent, adults and families. It is possible to apply dialogical approaches in many different settings.

But what has surprised me is the enormous difficulty therapists with extensive experience in a particular therapeutic method have in adopting a dialogical way of working with clients. For as I see it, dialogue is not a method; it is a way of life. We learn it as one of the first things in our lives, which explains why dialogue can be such a powerful happening. Because it is the basic ruling factor of life, it is in fact very simple. It is its very simplicity that seems to be the paradoxical difficulty. It is so simple that we cannot believe that the healing element of any practice is simply to be heard, to have response, and that when the response is given and received, our therapeutic work is fulfilled (Seikkula & Trimble, 2005). Our clients have regained agency in their lives by having the capability for dialogue. However, this does not mean that we would not need experience and advanced therapy training because in systematic training staff members may learn to tolerate more the uncertainty of the crises and to stay in the simpler instead of aiming at complicated interventions.

References


