There is no fixed time for admission. Admission is discussed for every case. Guests do not pay any fee; they have no restrictions for going out or to come back at night. Internal rules are kept to a minimum. It is not allowed to introduce weapons or to act violently against other guests. It is not allowed to keep alcohol and street drugs, but there is no entry ban for those who come back drunk or under the effect of street drugs. The centre has no educative purpose. It does not aim to change the guests' behaviour and choices. The centre just represents an opportunity for everybody to experiment for themselves in total freedom.

The administration of the centre has always been self-funded, supported by private structures and awards from the public services. No funds are asked or accepted from psychiatric services, nor do they derive from the care of psychiatric patients. People can be admitted to the centre only if they are below the subsistence level. Associazione Penelope and its experience show every day that it is possible to live without psychiatric practice and to give practical solutions to the conflicts among people.

The main reason behind the greater part of psychiatric hospitalization is that it is difficult to live with a psychiatric patient and it is difficult for a psychiatric patient to live on his/her own. These are practical troubles that need practical answers. Having found an antipsychiatric alternative to the family and hospitalization is for us the right way to avoid psychiatry without reproducing its practices. If what I said seems impossible, well, bear in mind that the impossible is our aim.

Jaakko Seikkula and Birgitta Alakare

Open Dialogues

Can you imagine a psychiatric practice, in which, concerning a psychotic or other severe crisis in the family, the first meeting is organized within one day after the contact; in which both the patient and family members are invited to participate in the first meeting and throughout the treatment process for as

long as needed; in which all relevant professionals—from primary care, from psychiatry, from social care, etc.—who have some contact to this family are invited to participate in the same meetings and share openly all their thoughts and opinions about the crisis and what should be done? And that the professionals would stay the same for as long as help is needed? And that all discussions and treatment decisions are made openly while the patient and family members are present?

These are the basic guiding principles of the Open Dialogue approach, a new treatment method centred around family and social networks, that has been put into practice in the Western part of Finnish Lapland. The development of the new approach started in the early 1980s. Jaakko (first author) became a psychologist in the Keropudas hospital in 1981, one year after the chief psychiatrist Jyrki Keränen had taken charge as the chief of the hospital. Birgitta (second author) started her career as medical doctor in 1982 in the Keropudas hospital. Later, she specialized in psychiatry. Birgitta has been working as the chief psychiatrist in the health district for years. One important member of the team, psychologist Kauko Haarakangas, came in 1986 and is presently working as the chief psychologist. Along with several newer team members we came up with the idea of building a family centred system and luckily had the control of treatment planning for admitted patients and could thus initiate new practices and ensure their continuation.

The new approach did not emerge automatically from one decision, but developed by analysing problems in our practice and trying to find solutions to them by re-organizing the system. There were different phases in the process of developing open dialogues, with the following critical steps: (1) in 1984, open family treatment meetings began to take the place of systemic family therapy in the hospital; (2) in 1987, a crisis clinic was founded to organize case-specific teams for inpatient referrals; and (3) in 1990, all the mental health outpatient clinics started to organize mobile crisis interventions teams. This meant that since early 1990s the entire psychiatric system in the small Länsi-Pohja province located in the South Western part of Finnish Lapland has followed the ideas described here. In this paper, we describe the basic ideas of Open Dialogues. We include the approach in Western Lapland and

add some elements that are applied in different contexts in many countries where the ideas of Open Dialogues have been adopted.

Before Opening the Boundaries

When we 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 of patients diagnosed with schizophrenia. This is not a big surprise since the Keropudas hospital was at that time occupied with dozens of long term patients who had been considered "incurable" and were thus transferred to the B-mental hospital which was designated to receive patients who needed long term inpatient treatment. In shifting to a more acute treatment, the Keropudas staff had to learn how to work with the psychological resources of the patients with psychotic problems.

In Finland, psychotherapeutic practice has been conducted as one part of public health care. Especially important has been the program and research developed in a Turku psychiatric clinic since the 1960s by professor Yrjö Alanen and his team. Starting with individual psychodynamic psychotherapy, the Turku team integrated family perspectives into their treatments in the late 1970s and called the approach Need-adapted Treatment to emphasize that every treatment process is unique and should be adapted to the varying needs of each patient.

Systematizing their ideas in the context of the Finnish National Schizophrenia Project in the 1980s Need-adapted Treatment emphasized (1) rapid early intervention; (2) treatment planning to meet the changing and case specific needs of each patient and family; (3) attention to therapeutic attitude in both examination and treatment; (4) seeing treatment as a continuous process, integrating different therapeutic methods; and (5) constantly monitoring treatment progress and outcomes (Alanen, 1997; Alanen, *et al.*, 1991). Taking into account the long tradition of schizophrenia treatment in Finland, in Western Lapland the Open Dialogue (OD) idea meant that psychotherapeutic treatment is organized for all patients within their own particular support systems.

What is Open Dialogue?

The name Open Dialogue was first used in 1996 to describe the entire family- and social network centred treatment. It includes two aspects: first, the meetings in which all relevant members participate from the outset to generate new understanding by dialogue; secondly the entire system of psychiatric practice is contained in one geographic catchment area.

The main forum for dialogues is the treatment meeting where the major participants in the problematic situation join with the patient to discuss all the relevant issues. All management plans and decisions are made with everyone present. According to Alanen (1997) the treatment meeting has three functions: (1) to gather information about the problem, (2) to build a treatment plan and make all decisions necessary on the basis of the problem which was described in the conversation, and (3) to generate a psychotherapeutic dialogue. On the whole, the focus is on strengthening the adult side of the patient and on normalizing the situation instead of focusing on regressive behaviour (Alanen, *et al.*, 1991). The starting point for treatment is the language of the family, how each family has, in their own language, described the patient's problem. Problems are seen as a social construct reformulated in every conversation (Bakhtin, 1984; Gergen, 1994; 1999; Shotter, 1993a; 1993b). All persons present speak in their own voices—and, as Anderson (1997) has noted, listening becomes more important than the manner of interviewing. Team members can comment on what they hear to each other as a reflective discussion while the family listens (Andersen, 1995).

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 leading the dialogue. On some occasions, there is no prior planning regarding who will take 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. This is the best option when the treatment unit is accustomed to conducting family meetings in a structured way. The first questions are as open ended as possible, to guarantee that family members and the rest of the social network can begin to speak about the issues that are most relevant at the moment. The team does

not plan the themes of the meeting in advance. From the very beginning the task of the interviewer(s) is to adapt their answers to whatever the clients say. Most often, the team's answer takes the form of a further question, which means that subsequent questions from team members are based on and have to take into account what the client and family members have said. If the patient does not want to join the meeting, we discuss with family members whether or not to continue the meeting. If the family wants to continue a staff member informs the patient that s/he can return if s/he wants. During this discussion we do not make decisions concerning the patient. If we hear something so dangerous that we feel required to act, we inform the patient before doing so.

Everyone present has the right to comment whenever s/he is willing to do so. Comments should not interrupt an ongoing dialogue. Every new speaker should adapt his/her statement 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, specific phrases are introduced to describe the client's most difficult experiences. When the staff members have to remind the family of their obligations, 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 clients' own words, 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 whether or not decisions have been made, and if so, what they were. The length of meetings can vary, but usually 90 minutes is adequate.

Practical Guidelines

In Finland, several effectiveness and treatment process evaluations of the Open Dialogue approach have been completed employing an action research methodology (Aaltonen, *et al.*, 1997; Haarakangas, 1997; Keränen, 1992; Seikkula, 1991; 1994; Seikkula, *et al.*, 2003; 2006) By summarizing the observations in these studies, seven main principles emerged: 1) immediate support; 2) a social networks perspective; 3) flexibility and mobility; 4) responsibility; 5) psychological continuity; 6) tolerance of uncertainty and 7) dialogism.

It is worth noting that these principles came out of the research and were not principles planned before and then followed. Later on, more general ideas about good treatment were added. In the following, we will describe the principles as guidelines for treatment focusing on dialogue. 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 in crisis situations.

Responding Immediately

The best start in a crisis is to act immediately, and not, for instance, to wait for the patient with psychosis to become more coherent before a family meeting. It is preferred that the first response be initiated within 24 hours. The staff of the response unit should arrange a meeting regardless of who first contacted the response unit. In addition, 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. All, including the patient, participate in the very first meetings during the most intense psychotic period.

A common observation seems to be that patients experience something that is unappreciated by the rest of the family. Although patients' comments may sound incomprehensible in the first meetings, after a while it becomes apparent that the patient was actually speaking of real incidents in their lives. Often these incidents include some terrifying elements or a threat that they have 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 pre-

viously been verbalized. This is also the case in other forms of difficult behaviour. In extreme anger, or depression, or anxiety, the patient is speaking of themes that have not previously been aired. In this way, the main person in the crisis, the patient, reaches for something unreachable by others in their surroundings. The aim of the treatment becomes the expression of experiences that did not have words or a shared language.

During the first couple of days of a crisis, it seems possible to speak of things that are difficult to discuss later. In the first days, hallucinations may be handled and reflected upon, but they easily fade away, and the opportunity to deal with them may not reappear until after several months of individual therapy. It is as if the window for these extreme experiences only stays open for the first few days. 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 critical 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 agencies, such as State employment health insurance agencies, vocational rehabilitation services, fellow workers or the supervisor at the patient's workplace, neighbours or friends.

Social networks can be seen as relevant in defining the problem itself. A problem becomes a problem after it has been defined as one in the language of either those closest to the patient or by the patients themselves. 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 abuse. Anderson and Goolishian (1992) said that the one seeing the problem becomes a part of the problem-defining system. From a network perspective, all these individuals should be included in the process, because

the problem is resolved only if everyone who all has defined it as a problem no longer refers to it as such.

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 knows of the situation or who has been involved? 2) Who could be of help and is able to participate in the first meeting? And 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. Also, the one who has made contact with the services can decide who they do not want to participate in the meetings. If the proposal for a joint meeting is done 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 connection with the current situation or previously. All of these parties should be invited sooner rather than later. If the other professionals cannot attend the first meetings, a joint meeting can be arranged later.

The social relations of our clients can be included in many forms. They can be present, or if some of them cannot manage to attend meetings, then the clients can be asked if they want to invite others who know of their situation and who could possibly help. Some member of the network can be given a task of contacting them after the meeting and relaying the absent persons' comments in the next joint meeting. Those present can be asked, for instance, "What would Uncle Matti have said if he was present in this conversation? What would your answer be? And what would he say to that?"

Adapting Flexibly to Specific and Varying Needs

Flexibility is guaranteed by adapting the treatment response to the specific and changing needs of each patient and his/her family using therapeutic methods best suited to each family. Each patient needs to be treated in a way that best suits their specific language, way of living, possibilities for making

use of specific therapeutic methods, and the length of treatment time that fits the actual problem, instead of applying a generic program without variation from case to case. During the first 10-12 days of a crisis, the need is quite different compared to three weeks later. For instance, during the most acute phase, it is advisable to have the possibility of 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 meeting place should be jointly selected. If the family approves, the best place might be the patient's home; in other situations, it might be an emergency department or a psychiatric outpatient clinic, if the family sees that as more suitable. Home meetings seem to prevent unnecessary hospitalisations, since the family's own resources are more available in a home setting (Keränen, 1992; Seikkula, 1991).

New ideas for psycho-social treatment of psychosis have recently been developed. Most new programs still follow an illness model, in which psychotic reactions are seen as signs of an illness that families would benefit learning about so as to avoid over-stimulation and relapses. In these approaches, psychoeducational models are used. Families are informed about the illness and family members are trained in managing stressful interactions. In most cases, it involves a therapeutic program that is followed similarly in each case. Such programs are relatively easy to evaluate scientifically, but the problem of adapting them to individual needs remains. Families can easily refuse to participate (Friis, *et al.*, 2003). To avoid this, the need-adapted approach seems better at taking into account the uniqueness of each treatment process. It seems to suit the Nordic system, in which every psychiatric unit has total responsibility for all clients in its catchment area.

Taking 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 may be the patient herself, a family member, a referring practitioner or other authorities, such as a school nurse, for instance.

Organizing a specific crisis intervention or acute team is one possibility. Thus all staff members will know who to contact if clients have contacted them. This principle means that it would no longer be possible to answer a request for help by saying "this has nothing to do with us, please contact the other clinic." Instead, one can say, for instance, "It sounds like, to me, that alcohol abuse may be involved in your son's problem. Would you allow me to invite someone from the alcohol abuse clinic to join us in the meeting tomorrow?"

In the meetings, decisions are made as to who will 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 ward.

The team mobilized for the first meeting should take all the responsibility needed for analysing 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, s/he 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.

Guaranteeing Psychological Continuity

The team takes responsibility for the treatment for as long as needed in both outpatient and inpatient settings. This is the best way to guarantee psychological continuity. Forming a multi-disciplinary team early increases the possibilities for crossing boundaries of different treatment facilities and preventing drop outs.

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 meet three or five times and then refer the patient to

other authorities. In these circumstances, even in the first meetings, too much focus is on the actions that are taken and not on the process 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 these methods complement each other. For instance, if individual psychotherapy is recommend 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 in 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 joint treatment process. This is particularly important to consider 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 answers to the actual problem. The aim is to mobilize the psychological resources of the patient and those nearest to him or her so as to increase the agency in their own life, by generating new stories about their most extreme experiences. This is furthered by building up a sense of trust in the joint process. For instance, in psychotic crises, an adequate sense of security can be generated by meeting every day at least for the first 10-12 days. After this, meetings can be organized on a regular basis according to the wishes of the family. 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 dissolve by itself. Recommendation of neuroleptic drugs should be discussed at least in three meetings before implementation if we think the drugs are necessary.

In contrast, illness-oriented approaches during the early phase of treatment focus on decreasing or ameliorating symptoms with psychiatric drugs. For psychotic patients, these are typically neuroleptics. Psychiatric drugs can help, of course, but the risk is that they, decrease psychological resources at the same time. Neuroleptic drugs 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. It is helpful to consider maintenance psychiatric drugs at least two or three meetings before starting them. This conclusion is verified in the studies we will describe later. In our study, only 29% of acutely psychotic patients used neuroleptic drugs during the five year follow-up period.

Besides the practical aspect 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. To return to our example: 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 abuse. Already in the very first meeting, it is good to reserve some time for reflective discussion among the team apart from these different or even contradictory perspectives. 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 understanding 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 (Promoting Dialogue)

In meetings, the focus is primarily on promoting dialogue and secondarily on promoting change in the patient or in the family. Dialogue is seen as a forum through which families and patients are able to acquire more agency in their own lives by discussing the problems (Haarakangas, 1997; Holma & Aaltonen, 1997). A new understanding is generated in dialogue. (Bakhtin, 1984; Voloshinov, 1996; Andersen, 1995). For a professional, this means eliciting new aspects of being an expert in whom clients can trust. Professionals have to become skilful in promoting dialogues through which their specific expert knowledge becomes rooted in the context.

Effectiveness of Open Dialogues

In Western Lapland, the effectiveness of Open Dialogue has been assessed in follow-up studies for first-episode psychotic patients. The results compared to treatment as usual are promising (Seikkula & Arnkil, 2006). In comparing *the treatment outcomes* of patients diagnosed with schizophrenia between Open Dialogue and treatment as usual, the following differences were noted at the two-year follow-up (Seikkula, *et al.*, 2003):

- In the comparison group, the patients were hospitalised significantly longer (approximately 117 days compared to 14 days in the Open Dialogue (OD) group.
- All the patients in the comparison group used neuroleptic drugs compared to one third in OD.
- Fewer family treatment meetings were organized in the comparison group (approximately 9 compared to 26 in OD). The variation was large in each group, in the OD group from 0 to 99 and in the comparison group from 0 to 23.

Treatment as usual seemed to emphasize the controlling aspects of treatment, such as hospitalization and the use of neuroleptic drugs. Family members were invited to the discussion in most cases, but family meetings were not focused as much as in Open Dialogue. Individual psychotherapy was used with equal frequency in each group—in about half of the treatments—which indicates that the integration of different therapeutic methods is taking place in both traditional as well as in Open Dialogue treatment.

When comparing *the outcomes*, Open Dialogue patients diagnosed with schizophrenia seem to recover better from their crises. The following differences emerged at the two-year follow-up:

- At least one relapse occurred in 71% of comparison group patients compared to 24% in the OD group.
- Comparison group patients had significantly more residual psychotic symptoms compared to the OD group. Some 50% of comparison group patients had at least occasional mild symptoms, compared to 17% of OD patients.
- The employment outcome was better with OD patients, of whom only 19% were living on a disability pension compared to 57% of the comparison group patients.

The results with Open Dialogue patients remained positive at the five-year follow-up (Seikkula, *et al.*, 2006). Only 29% of OD patients experienced one or more relapses (39% in the comparison group). Recovery from psychosis occurred equally in both groups. After five years, 82% of OD patients (76% in the comparison group) had no residual psychotic symptoms. Employment status was better than in any other outcome studies, with 86% of the OD patients (72% in the comparison group) returning to their studies, work, or to active job-search.

Conclusions and Reflections

The outcome results actually show a remarkable change in psychiatry. As one known professor of psychiatry noted in a personal communication, “we have not previously seen any of these kinds of results with psychosis.” In the small province in Western Lapland, first signs have emerged that the incidence of schizophrenia has decreased, from 33 new patients per year per

100,000 inhabitants in 1985 to two during the first years of 2000s. A research project has been undertaken to analyse this phenomenon and its relations to the new treatment approach.

The above information suggests that our approach to psychiatric crisis has changed. We are used to thinking of psychosis as a sign of schizophrenia and as a relatively stable state that afflicts the patient throughout his/her entire life. For instance, 1/3 of the patients with schizophrenia are said to need ongoing treatment, 1/3 will need intermittent treatment, and 1/3 will fully recover and actively work. In the few long-term follow-up studies of first time psychotic patients, after five years more than a half, often about 60% are said to be living on a disability pension (Svedberg, *et al.*, 2001; Lenior, *et al.*, 2001).

The positive outcomes in Open Dialogue may indicate that psychosis no longer needs to be seen as 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 when so few actually need neuroleptic drugs, we can ask whether our understanding of the problem itself should be changed. Perhaps it is not the biochemical state of the brain that causes hallucinations, but, instead, hallucinations include real incidents of life and are one possible response to severe stress. This can occur in every one of us and no specific biological vulnerability is needed.

New ways of thinking about psychoses seem to have emerged in the new practice. Does this mean that 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 private social network and the professionals sphere. And it may 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 new aspects: not only to read books about medical interventions, but also to reflect upon the philosophy of our human views, of the possibilities how to generate dialogue and how to listen to people instead of dominating