SPEAKER NOTES

Open Dialogue: Mental Health Treatment in Northern Finland

Summarized by Thomas T. Thomas

About thirty years ago, the mental health services in Finland undertook an experiment in the selective use of antipsychotic medications, also known as neuroleptics, which are prescribed to manage hallucinations and delusions. Three hospital sites agreed to use these medications sparingly or not at all, while three others continued their current regimen, while all of them used psycho-social therapy as well. The sites that refrained from medication had better outcomes, and the patients who were never exposed to neuroleptics had the best outcome of all. Of those patients being treated for a first psychotic episode, two thirds received no medication, and of the remainder who received some medication, about half were able to discontinue its use after five years.

While most of the Finnish hospitals then reverted to the practice common in most developed countries of treatment with a combination of medications and psycho-social therapy, one area in northern Finland, which includes Lapland, broadened the non-medication approach into a treatment system that has since become known as Open Dialogue. In the 1960s and '70s, this area had one of the highest incidences of schizophrenia in Europe. Today, by applying Open Dialogue to first-episode patients, the recorded incidence is down to two cases per 100,000, and most of those cases do not become chronic. Schizophrenia seems to be disappearing there. And Open Dialogue is not an alternative approach but the primary system of treatment. As one clinician said, "It's how we work here."

At our March 27 meeting, NAMI East Bay board member Ed Herzog introduced an hour-long video on the Open Dialogue process and hosted a discussion afterward. The video was conceived, directed, and narrated by Daniel Mackler, a psychotherapist from New York who is also a filmmaker, writer, and musician. He interviewed various therapists, nurses, and family practitioners who currently use the Open Dialogue approach, as well as Jaakko Seikkula, a professor of psychotherapy at the University of Jyväskylä, Finland, who led the team that helped advance and refine the process over the past twenty years. The video also had commentary by Robert Whitaker, a journalist and author on medicine and science, most notably the recent *Anatomy of an Epidemic* (Crown, 2010). Whitaker's writings have challenged the treatment model used in most developed countries, where prescribing antipsychotic medications is considered the best practice, and where people accept the idea that a severe mental illness like schizophrenia necessarily leads to lifelong disability. For reasons of confidentiality, Mackler was unable to film the Finnish clients and family members who had experience of the Open Dialogue process.

The program has two fundamental principles:

1. Holding conversations that are inclusive, non-secretive, non-hierarchical, and value all voices. "Everyone's voice is important," said a nurse on the team. "This is a political thing," said another. "We aim at a democratic process where people can have their own say about treatment."
2. Therapists acting as teams and talking openly in front of clients and family. As one therapist said, "[The process] is not *about* them but *with* them."

This approach has its roots in the idea that mental illness is not a defect inside one person's brain but a problem involving his or her relationships. In that context, the team listens to the content of hallucinations, such as hearing voices, and delusions, such as strange beliefs or notions, rather than challenging them. These experiences are relevant to the client, who may not have the words to express what's wrong in other ways. So hallucinations and delusions are relevant to everyone involved, providing clues to past difficulties or traumas and how to heal them. "For the first time," one nurse said, "the patient can tell his own experience with others listening and hearing it." However, in Open Dialogue this discussion passes through what another nurse called "the lens of therapy."

When a person shows signs of a first psychotic break, a team of psychologists, therapists, and social workers goes to the family's home and begins a dialogue among the patient, family members, and themselves to explore the situation. These intensive sessions might continue for several weeks, and usually at least one team member stays with the family around the clock. During the sessions, everything is said out in the open—even as the team discusses the situation and shares ideas about diagnosis and prognosis. "We will talk and bounce ideas off each other," one nurse said, "then ask the patient, 'How does it feel to hear this?' "

Said a therapist: "We are not professionals who have to know everything right away. It's a two-way collecting, not me treating someone. I have to risk myself by entering into a conversation." Jaakko Seikkula, who helped pioneer the process, commented, "We are sitting together to understand and to create dialogue, not to get solutions. Solutions happen as a consequence of dialogue."

The Open Dialogue process is markedly different from treatment programs in the rest of the developed world, where the psychologist or psychiatrist is considered the expert who is rendering a judgment and making the plans, while the client is a subject taken out of the home or other social setting and placed in the hospital's strange environment. In fact, the team's clinic in northern Finland has only one consultation room—although if clients and family want to meet the team in a neutral setting, they can use rooms in the local auditorium. The patient and family members are given choices and their points of view are considered most important.

Another difference is the speed of treatment. When a person in crisis calls the clinic, the team scrambles to meet him or her as soon as the call comes in. There is no wait of days or weeks for an appointment, and then more time for follow-up.

The therapy teams not only work closely together, but they know and like each other personally and meet socially. "That makes it easy for us to work in this

way." They develop the kind of rapport that lets them direct the conversation among themselves with a glance or a gesture.

This kind of rapid response and labor-intensive team involvement would seem prohibitively expensive. When Mackler asked the team about that, they at first said mental health in Finland is a state-paid system free to the client. The team sends their bill to the municipality. As to the relative cost, however, the consensus was that meeting in teams is more efficient in the long run, and helping first-episode clients avoid a chronic illness and remain part of society is the most economical outcome.

Open Dialogue does not completely deny the client access to medication, although the team members were mystified when Mackler asked them about the professional risks of not medicating their patients and described the situation in other developed countries, where medication is considered the best practice and psychiatrists work within a model of drug-based care. In Lapland, they said, everything is based on results of treatment, and they don't need to administer neuroleptics to prove it.

They will sometimes administer medications, but selectively, usually small doses of aspirin or sleeping pills to treat immediate symptoms of pain or sleeplessness. If the patient needs a neuroleptic—and only about 30% do during a given year—then the team prescribes the minimum dose, usually just enough pills for a day or two, to relieve the worst symptoms and avoid side effects. The decision to medicate is discussed with the client and family members, including what the team hopes to accomplish through medication.

Generally, however, the team seeks other ways to help the client, including adjusting his or her patterns of sleep, diet, and exercise; taking up yoga and meditation; and stimulating friendships and service opportunities. "We usually have so many other options that we don't have to think about medication."

Open Dialogue is about making meaning, the team members said, and neuroleptic medications only get in the way of meaning. The client is experiencing some kind of dilemma in his or her relational life, and when you start to work on that, the symptoms go away.

In other developed countries, the patient is put in a hospital as a place of shelter and safety. In northern Finland, the team tries to create that safe place in the home, and they find it's often easier to work there.

The Open Dialogue team members in northern Finland generally had little experience of outside therapy systems, but those who did were not impressed. "The psychiatrist sat and just listened to the patient and other team members. Then he said, 'I've heard enough,' and he walked away. He wouldn't participate in the dialogue at all!"