Dialogue does cure: Why? What makes Open Dialogue than effective to help in most severe crises?

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Open dialogue in psychosis Western Lapland – 2years follow-up in three studies

	API 1 (1992-1993)	ODAP2 (1994-1997)	ODAP3 (2003-2005)
N/IT groups	N=33/39	N=42/51	N=18/27
Age	26.6	26.8	20.2
Schizophrenia (schform)	64%	54%	39%
Use of neuroleptics	26%	26%	50%
• Ongoing	15%	11%	28%
Employed or jobseeking	74%	91%	84%

19 years follow-up: Comparison OD vs Treatment As Usual in Finland (Bergström et al., 2018)

	OD N=108 Western Lapland	TAU N=1763 /% Rest of Finland
• Mortality by illnesses	2.8	9.2
• Hospital days (over 30)	18	94
• Ongoing contact after 19 years	28	49
• On neuroleptic	36	81
• On disability allowance	33	61

Worse recovery……(Jääskeläinen et al., 2013: A Systematic Review and Meta-Analysis of Recovery in Schizophrenia. Schizophrenia Bulletin vol. 39 no. 6 pp. 1296–1306

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Period	Recovery rate
- 1941	13%
1942 – 1955	18%
1956 – 1975	17%
1976 – 1995	10%
1996 -	6%

Dialogue does cure - why?

1) Dialogic practice creates a new human view, in which the best mental health care is to accept people's emotional experiences instead of aiming at eliminating mental symptoms or changing the family.

2) Dialogical practice adopts and utilizes the latest intersubjective knowledge that a person is an active participant in embodied rhytmic interaction from birth. Reality always arises in a relationship. The management of severe mental health crises takes into account the person as a full bodily participant in a constantly ongoing stream of interaction, dialogue. Baby is an active author of her own growth. In the very same way, every people in need of help is an active author of her/his help.

3) Open dialogues have developed as one form of family therapeutic work, but the aim is no longer to make an intervention to change the family system, but to create a shared experience, in which new language is created for managing the most difficult experiences. Families are not objects of care but invaluable partners for the profesionals.

4) The dialogical practice utilizes the knowledge that the human mind is constructed as a bodily process that allows the human being to be considered as a whole and thus transcends the dualistic conception of man. The Relational Mind. Reality is contextual, arising in each situation. A holistic bodily understanding, makes psychotherapy possible much more widely than before, because no special inner linguistic insight is needed as a precondition, and the sharing of emotions already is healing.

5) Dialogical practice makes it possible to understand psychotic behavior as a necessary human response to extreme stress. Psychosis is not a psychopathological condition or illness, but a person has a lot of own resources to cope with a crisis. In this way, it has been possible to drastically reduce the use of neuroleptic medication and prevent the harmful side effects of medication.

6) Dialogue improves reflectivity. Dialogue orientation has created ways to determine (DIHC method) the quality of dialogue. Healing dialogues can be explored and the best possible ways to help another and thus develop a conversation that supports clients ' own reflections.

7) Open dialogues are based on systematic scientific research in every day clinical practice as naturalistic research settings. The task of scientific research is to develop the practice that helps people on a broad scale, exploring both treatment outcomes and processes of dialogues. I am not familiar with any psychiatric treatment model that has been so extensively scientifically researched.

- 1) Dialogic practice creates a new human view, in which the best mental health care is to accept people's emotional experiences instead of aiming at eliminating symptoms or changing the family.

- “... authentic human life is the open- ended dialogue. (…) To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. ***In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds. ”***(M. Bakhtin, 1984)

“Dialogue here is not the threshold to action, it is the action itself. It is not a means for revealing, for bringing to the surface the already-made character of a person; no, in dialogue a person not only shows himself outwardly, but he becomes for the first time that which he is – and, we repeat, not only for others but for himself as well. To be means to communicate dialogically.” (Bakhtin, 1984, 252)

“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)

- 2) Dialogical practice adopts and utilizes the latest intersubjective knowledge that from the first day on a person is an active participant in embodied rhythmic interaction. Reality always arises in relationships.
- Baby becomes an active author/co-author of her own growth. In the very same way, every people in need of help is an active author/co-author of her/his help, not a receiver or consumer of services.
- The management of severe mental health crises considers the person as a full huma being in a constantly ongoing stream of interaction, dialogue.

To intersubjectivity

- “Life is not psychology - it is (dialogic) music ” (Colwyn Trevarthen)
- ”I see myself in your eyes” (M. Bakhtin)

Movement is the first language (Maxine Sheet-Johnstone 2010)

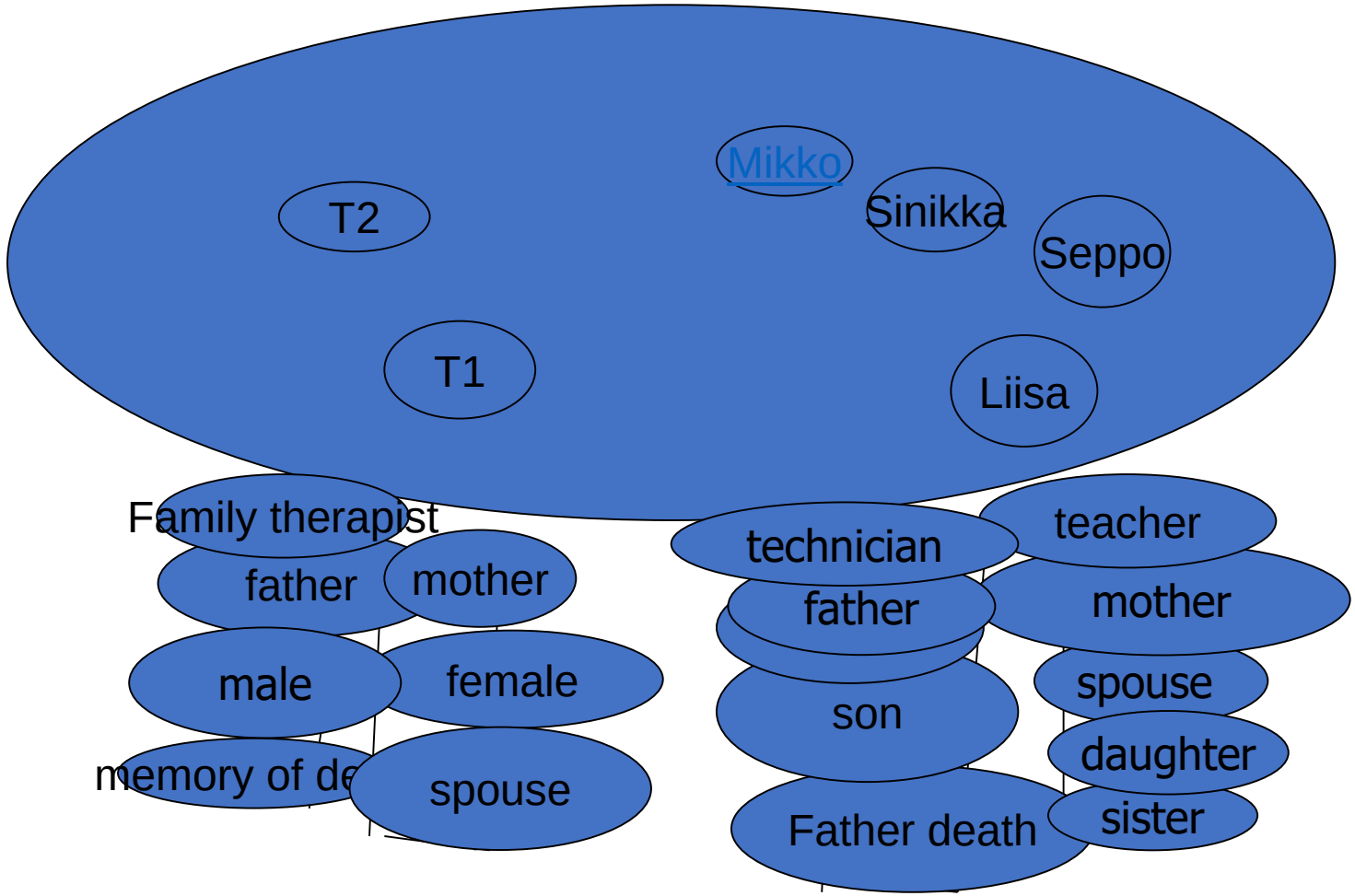
- Moving in rhythm
- Regulation of affective arousal
- AND
- Communicative act

Language of emotional experiences

- Movement
    - Affects or sensing
    - Speaking of emotions

- ”We are now experiencing a revolution. The new view assumes that the mind is always embodied in and made possible by the sensori-motor activity of the body. (…) Mind is intersubjectively open, since it is partially constituted through its interaction with other minds” (D. Stern, 2007, 36)

- 3) Open dialogue has developed as a form of family therapeutic work, but the aim is not to change the family system. The aim neither is to focus only on the narratives of each family member, but to create a shared emotional experience, in which new language is created for the most difficult experiences.
- Families are not objects of care but invaluable partners for the clinicians.



Horizontal polyphony

- ”Vertical polyphony” = inner voices

Two simultaneous histories

1. Embodied living in the present moment
   - shared experience
   - implicit knowing
   - comments about the present experience

2. Narratives that we tell of the past incidents, experiences and things
   - meanings constructed

1: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 present
- Neither themes nor form of dialogue are planned in advance

2: GENERATING NEW WORDS AND LANGUAGE

- The primary aim in the meetings is not an intervention changing the family or the patient
- The aim is to build up a new joint language for those experiences, which do not yet have words

3: STRUCTURE BY THE CONTEXT

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

SIMPLE GUIDES FOR THE DIALOGUE IN PRESENT MOMENT

- Prefer themes of the actual conversation instead of narratives of past - be realistic
- Follow clients' stories and be careful with your own openings – repeat the said (and imitate movements)
- Guarantee response to spoken utterances. Responses are embodied, comprehensive
- Note different voices, both inner and horizontal
- Listen to your own embodied responses
- Take time for reflective talks with your collegues
- Dialogical utterances, speak in first person
- Proceed peacefully, silences are good for dialogue

MAIN PRINCIPLES FOR ORGANIZING OPEN DIALOGUES IN SOCIAL NETWORKS

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

- 4) The dialogical practice utilizes the knowledge that human mind is constructed as an embodied process to meet with full human being and thus transcends the dualistic conception of man.
- The Mind is relational.
- Reality is contextual, arising in each situation. An integrated, embodied view makes psychotherapy possible more than before, because no special inner linguistic insight is needed as a precondition for psychotherapy. Sharing of emotions already is healing experience.

Responding to the prosody, not the content

- Clients respond more to *how the* therapist says something than *what* the therapist says. They attend primarily to (a) prosody – pitch, and the rhythm and timbre of the voice – and also to (b) body posture, (c) gesture, and (d) facial expression. (Quilman, 2011)
- The pitch of the voice becomes higher before a re-formulation (Peräkylä, 2013)

Synchronization includes clients and therapists

- Synchronization of body movements increases alliance and good outcome (Ramseyer & Tschacher, 2011)
- Smiling as affect regulation both in individual therapy (Rone et al., 2008) and in couple – therapist triad (Benecke, Bänninger- Huber et al., 2005)
- Therapy training increases symphatetic orientation in EDA (Kleinbub ym., 2013)

The highest stress vector of the client during therapy session

C: mm (nodding, wiping tears from her cheek)

T1: earlier you did not notice it and well (.) this abuse it like then (.) went on

C: yeah (wiping tears) it went on

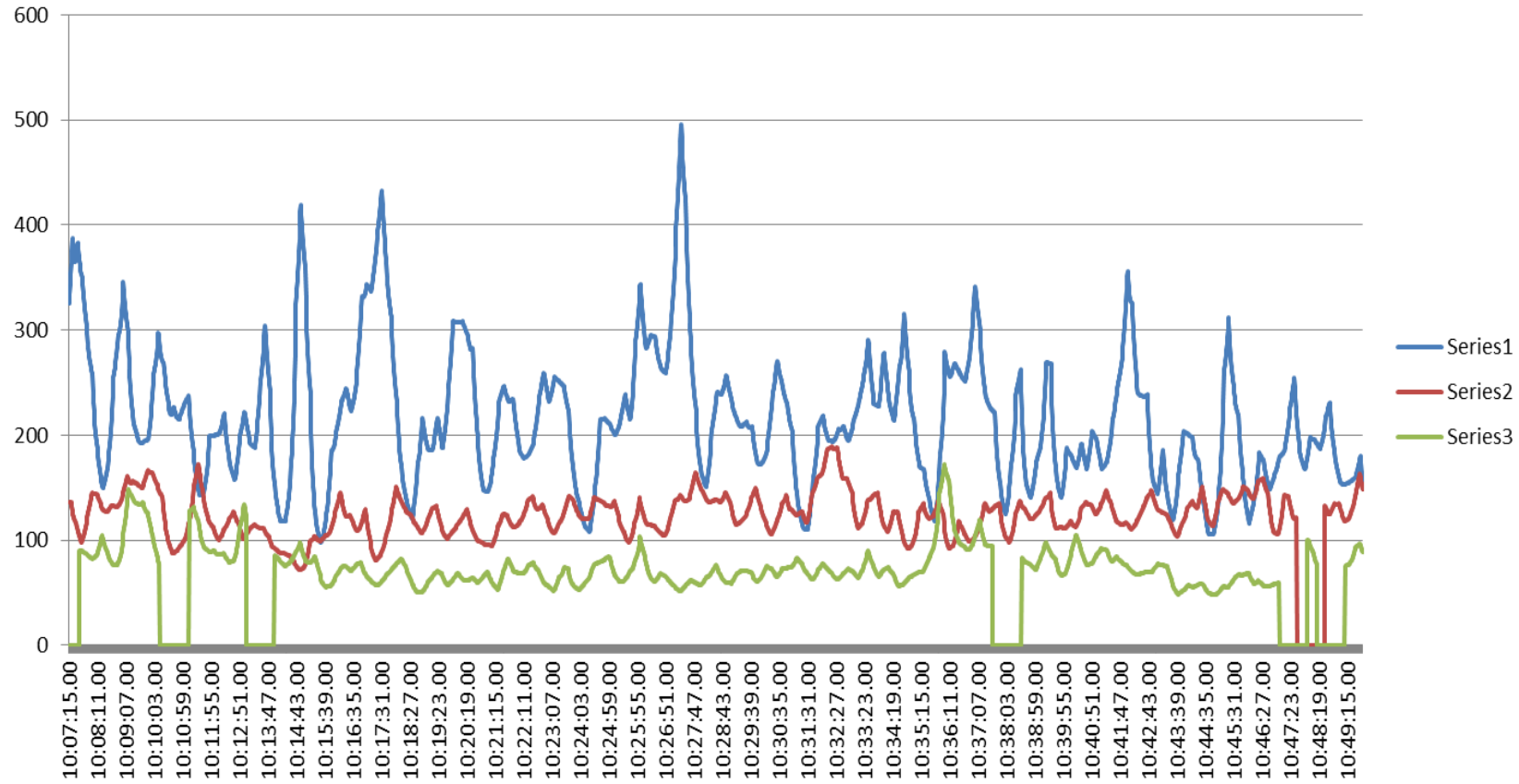
T1: mm

C: so that I must only le- no – less be in touch ((with them)) so that I myself feel well (nodding)

T1: but is it so that now that you see it that you have been abused in your relationships, that you now have the bad feeling about how you have been abused and that you have not been respected (.) which was not (gestures with his hand away from the client) there earlier (.)or was it there even then

C: (wiping her tears) well that was the time of performing I was a performer then

T1: (coughs) yeah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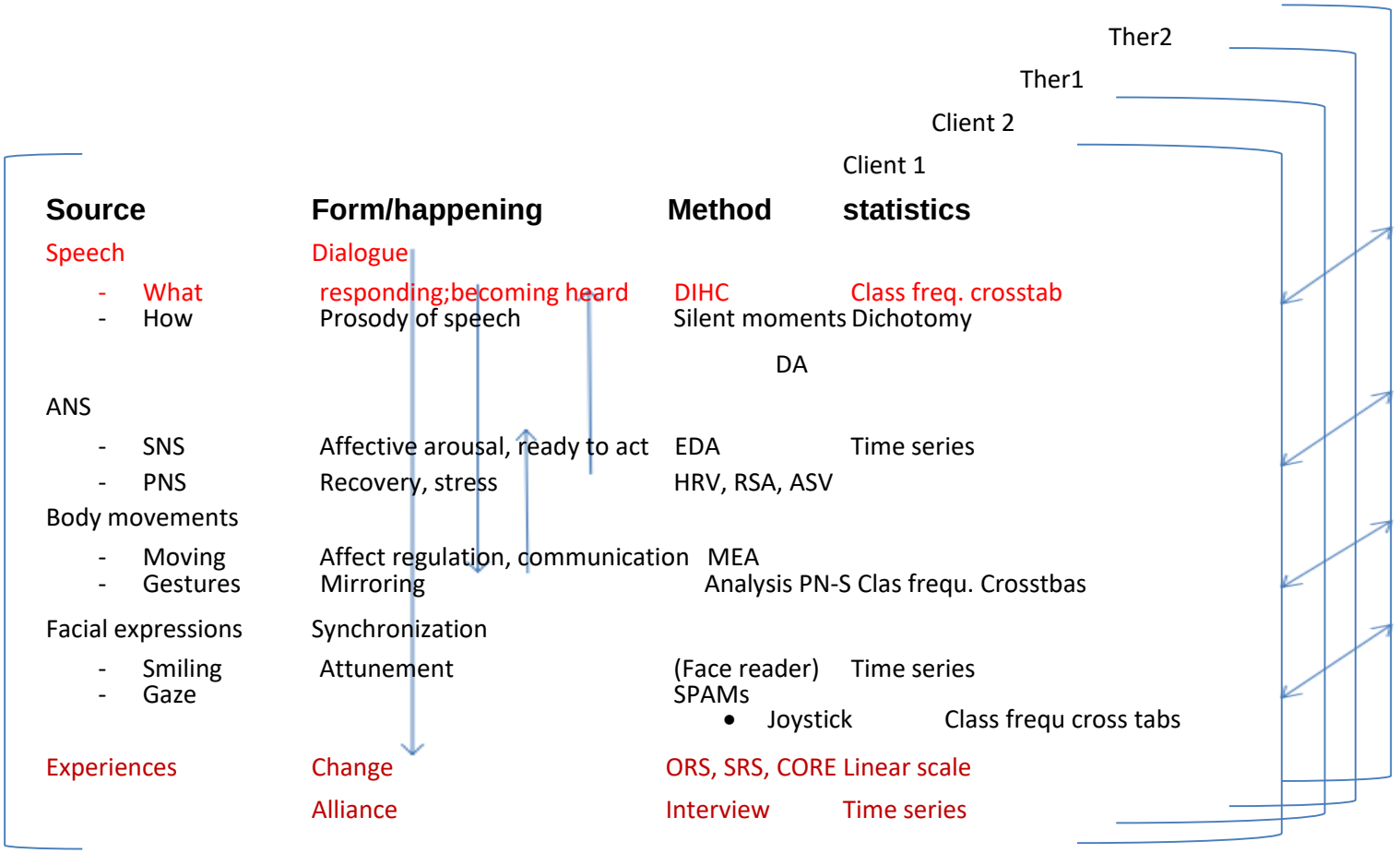
Inter- and intrasubjective synchronization in couple therapy with two therapists



Elements of synchronization

- Reactions of ANS (Sympathetic nervous system arousal) in concordance to each other – embodied emphatetic experience?
- In a single episode not everyone in concordance to each other
- Most stressfull episodes may happen during the speech of others in the meetings, even during the reflective talks – sensitivity of saying
- Change in prosody and rhytmicity of dialogue enhances the clients to deal with emotional issues – importance of silent moments
- Critisism of the indetity of the other – SNS arousal
- Dialogical changes most often don’t happen during the SNS arousal, but after: Let’s live the affective experience and reflect about it afterwards

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5) Dialogical practice makes it possible to understand psychotic behavior as a necessary human response to extreme stress. Psychosis is not a psychopathological state or illness, but a necessary survival strategy in extreme stress. A person has a lot of own resources to cope with the crisis. In this way, it has been possible to drastically reduce the use of neuroleptic medication and thus prevent the harmful side effects of medication.

Three guiding hypothesis

1. ”Psychosis” as a category does not exist

2. Psychotic symptoms are not symptoms of an illness

- strategy of our embodied mind to survive strange experiences

3. Longstanding (”chronic”) psychotic behaviour is not an illustrations of deep psychopathology but of the failure of treatment in two respect

- treatment starts all too late

- non adequate understanding of the problem and human life leads to a wrong therapeutic response

In the conversation

1) Having relational focus – both between the people present in the dialogue and between the inner voices
2) Accepting non conditonally the experience of the other – do not challenge the notions of the reality if not asked

   ” I have never spoken with a schizophrenia patient”
3) Emphasize on the emotions and sensations of the experience and not so much on rational understanding
4) Being present in the conversation – ”stop everything else when psychotic epxerience are told!”

6) Dialogue improves reflectivity

Dialogue orientation has created ways to determine (DIHC method) the quality of dialogue. Healing dialogues can be explored and thus develop skills of dialogue that supports clients ' own reflections

7) Open Dialogue is based on systematic scientific research in every day clinical practice as naturalistic research settings. On a broad scale, the task of the research is to develop the practice that helps people, exploring both treatment outcomes and processes of dialogues.

I am not familiar with any psychiatric approach that would have been studied so extensively than OD 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)