Open Dialogue Therapy

Narrative therapy (Chapter 14) has become a widely recognised and distinctive approach to therapy, with its own journal, publishing house, conferences, research network, and training programmes. However, it is important to acknowledge that narrative sits within a wider family of therapy approaches that have started from a similar set of philosophical perspectives, but have developed in different directions. Perhaps the single most significant and influential of these approaches is Open Dialogue Therapy.

The concept of *dialogue* represents a central aspect of the conceptual vocabulary of therapy. Dialogue extends the concept of the therapeutic relationship by suggesting that it relies on the existence of a two-way, responsive, active engagement of each person with the other.

Open Dialogue is an approach to working with people experiencing severe mental health problems, developed by Jaakko Siekkula and his colleagues in Finland (Haarakangas et al. 2007; Seikkula and Arnkil 2006; Seikkula et al. 2006). In an Open Dialogue-based service, when a person, or their family, seeks help for a crisis in which one member is acting in a manner consistent with a diagnosis of schizophrenia, a team of three therapists is convened. Depending on whether the person is hospitalised, or being helped at home, the team members (drawn from a pool of psychiatrists, nurses, psychologists, social workers, and child guidance workers) will represent the helping networks that are most relevant for the person and their family. A first meeting is convened within 24 hours, attended by the person, their family, other key members of their social network, and workers from official agencies involved in the case. There may be daily meetings for the following 10–12 days. The focus of the meetings is on promoting dialogue, on the basis that new understanding is built up in the 'area between' participants (Seikkula et al. 2006). Rather than rush into the formulation of a treatment plan, or the prescription of medication, there is a high degree of tolerance of uncertainty: 'the psychotic hallucinations or delusions of the patient are accepted as one voice among others' (2006: 216).

The results of a five-year follow-up of patients who had received help through the Open Dialogue approach showed that over 80 per cent had returned to an active social life, with no recurrence of psychotic symptoms. These outcomes compare favourably with those obtained in other studies of first-onset psychosis. In addition, the introduction of the open dialogue model was cost-effective, with a 30 per cent reduction in psychiatric services costs over the period when this approach was introduced, arising from the reduced utilisation of inpatient beds.

The factors that appear to be responsible for the success of the open dialogue approach include:

- A social network perspective – key members of the person's social network are invited to participate.

- Flexibility – the therapeutic response is adapted to the specific and changing needs of each case.
- Psychological continuity – the team that is originally convened retains responsibility for integrating the experiences of all participants, for the duration of the process.
- Dialogue and tolerance of uncertainty – these maximise the active involvement of those who are participating, by ensuring that their views and suggestions are taken into account.

As in narrative therapy, Open Dialogue is built around a strategy of enabling people to tell their stories, and to begin to create new stories that provide scaffolding for different ways of acting. There is also a shared emphasis on the importance of enlisting community resources. A key difference between narrative therapy and collaborative therapy is that while the former specifies a sequence of therapist activities (e.g. externalising the problem) that will lead to 're-authoring', the latter approach is a more open, dialogical process, in which the shape and structure of the therapy may be created anew in each case.

Utilising an Open Dialogue approach can have significant implications for the therapists who are involved. As Haarakangas et al. (2007) put it, this way of working means that therapists move from being experts to becoming co-workers who 'walk together' with clients. Such a style of therapy can be intense and demanding for both clients and therapists (Lagogianni and Georgaca 2023; Schubert et al. 2021; Tribe et al. 2019). Because Open Dialogue is intrinsically flexible and responsive to individual circumstance, it can present complex administrative and staffing issues (Heumann et al., 2023; Pocobello et al. 2023). These challenges, in turn, make it hard to conduct conventional research into its effectiveness (e.g., randomised controlled trials). However, more descriptive types of research, such as following up with clients over many years post-therapy (Bergström et al. 2018), and interviews with clients and family members (Florence et al. 2021; Gidugu et al. 2021) have consistently reported positive client outcomes.

In recent years, Open Dialogue has moved beyond its origins in Finland and is being offered in many countries. Innovative developments include the use of peer group members (i.e., other service users) in OD sessions, and the application of OD with a wider set of client-presenting problems.

The research group lead by Jaakko Seikkula has undertaken a substantial programme of research into embodied and neurobiological aspects of the process of dialogue in therapy (see Chapter 20).

Open dialogue in action – the case of Martti

Sixteen-year-old Martti was attending a vocational college in a different city from his parental home when 'everything seemed to fall apart'. He became increasingly isolated and

irritable, stopped taking care of his hygiene, talked only in a mumble, and made rocking movements. His parents took him to a primary care centre, and he was admitted for one night. An open dialogue team was assembled and daily meetings were held with Martti and his parents. It was decided that he would return home, and all further meetings were held in his parents' home. At first, Martti said little, and looked up at the sky; his parents cried a lot. His sister returned home to be with him. Medication was considered, but Martti's parents did not like the idea, so no prescription was made. Gradually, Martti began to be able to sleep at night and to answer questions. After three months, there was a five-week break, at the request of the family. On resumption of weekly meetings, Martti reported that he wanted to return to college. The team members, and his parents, were concerned about this, and after considerable discussion it was agreed that open dialogue meetings would continue at the college, involving the principal of the school, Martti's closest teacher, and the school nurse. At the five-year follow-up meeting, Martti was in work and coping well with his life. He was considering entering individual psychotherapy to 'clarify to himself what had happened during his crisis'. This case, reported in Seikkula et al. (2006), illustrates the way in which a collaborative caring network can be established around a person in crisis, which the person can use to begin to put their life back on track.

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