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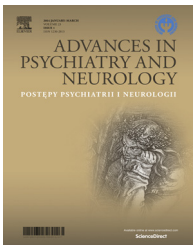

Review/Praca poglądowa

Open Dialogue as a contribution to a healthy society: possibilities and limitations

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ABSTRACT

This article proceeds from and explores the assumption that psychiatry has arrived at a crossroads, at which it has to choose, whether it will go on in the direction of neuroscience or turn back towards the individual, within its specific surroundings, with a focus on what the Open Dialogue Approach can contribute to the debate. Because of the comprehensiveness of this approach some changes should be expected in the treatment system. These affect the interests of many groups involved: patients, relatives, professionals and governmental agencies will profit in different ways, and some things might change that particular members of the different "lobbies" might see as a loss. Before getting close to a solution, the actual proceedings in Germany, based on experiences in Finland, are outlined, and finally some thoughts are shared on the difficulties of implementing the approach.

I want to start with a quote from an article by the Irish MD Pat Bracken, published just recently, in October 2014, in "World Psychiatry", the journal of the World Psychiatry Association [1]: "Psychiatry is currently going through a crisis of confidence. Some medical commentators have even questioned the very credibility of the profession. There are many indicators of this crisis. For example [there have been] [...] raised serious questions about the validity of the whole DSM [Diagnostical and Statistical Manual of Diseases] process [...]. It is clear that psychiatry has been a particular target of the marketing strategies of the pharmaceutical industry; strategies that have led to the corruption of evidence-based medicine in general. Much-heralded advances in antipsychotic psychopharmacology are now revealed as 'spurious'. Academic psychiatry's attempt to transform itself into a sort of 'applied neuroscience' has consumed enormous resources but delivered very little for patients".

Well, this is harsh criticism of scientific psychiatry, which in the years following the euphoria of the "decade of the brain" turned towards the idea of an almost complete neuroscience, in which expressions of human life are reduced to simple dysfunctions of neural circuits. That does not sound like a contribution to a healthy society.

He claims further that: "[...] meaning is not something that happens inside an individual mind or brain, but instead comes into our lives from the social practices that shape the world around us". "I contend, that good psychiatry involves a primary focus on meanings, values and relationships [...]."

This is a call for a hermeneutic approach towards mental health, based on the idea that the meaning of any particular

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experience can only be grasped through the understanding of the context, in which a person lives, and through which that particular experience has significance.

Comparing these quotes you find a description of very different views on the field, and it leads to a situation akin to walking through a minefield, in which it would be helpful to have some gap markers.

So what does Open Dialogue as a way of dealing with severely acute mental crisis, have to contribute to the discussion [2, 3]? The Open Dialogue Approach can be seen as something very new and revolutionary; but at the same time it is not at all new, but rather a collection of examples of best practice assembled to form a new pattern. It concerns the possible ways in which the creation of a treatment system meets the needs of patients, their families, professionals and the National Health Fund or (in other countries, e.g. Germany, insurance companies) – however widely these needs may differ.

Along with this approach goes a radical change in the system, so that from now on professionals will no longer have to meet the needs of patients and families or networks in their offices, but 'out there', in those places in which people's needs can be best met. This is in some way a real turnaround, but on the other hand best practice already exists in some places, where acute teams were created that were able to go in the direction of "home treatment", as for example in Finland, Norway and Sweden, the UK or nowadays also Germany. You heard something very profound about Open Dialogue and its development in Finland, and I want to point out that the results, having been researched over the years, are the best worldwide. Assertive Community treatment and Acute Crisis Teams have proven to be successful enough to prevent inpatient treatment. And yet there is a tendency these days to once again expand hospitals and increase the number of beds that can be used. This is, in spite of there being no evidence for the superiority of inpatient treatment compared to other forms. This is some kind of contradiction: the best results we claim for home treatment approaches, while again enlarging hospitals. Nowadays it is obvious why. It is a well-known rule that, if you want to know more about how things work, or how the cookie crumbles, follow the money. Not just in the field of health services. Everywhere in Europe we have, for historical reasons, a large number of bigger and smaller hospitals in each country. Hospitals are paid per bed. That is their only way to make money, so if they want to improve their economic situation they will ask for more beds. And the national boards of hospitals are certainly a strong force or lobby. But we also know that inpatient treatment is the most expensive kind when compared to any other approach [4]. And once again, there is no proof that this kind of standard care is successful in the long run anyway or, more importantly, superior to other forms of outpatient treatment. Much could be said about the findings of Robert Whitaker, a journalist, who investigated standard care outcomes worldwide. These findings cannot be reported here in more detail, but there is evidence that we should rethink large parts of our standard treatment system. Well, and that is what we have gathered here for.

So, "possibilities and limitations" are mentioned in the title of this lecture. These are present for all the different perspectives to be found somewhere in this field, which is hard to understand fully or even scrutinize because, whichever way we find into the future, some things will have to change and, with these changes, there will be winners and losers and at least some economic shifting. At the moment it is no more than a promise whether in the long run all of us would profit from new ways of cooperation.

Before I turn to opportunities and risks for the possible participants, a few words on the question of the limitations of the approach. When are you unable to, or in what kind of situation should you not try to work according to the principles and elements of the Open Dialogue? Though the approach has been developed for the treatment of networks, in which one member shows signs and symptoms of psychosis, it turns out that it is equally useful for other kinds of crises; and it depends more on the complexity of the situation, the needs of the patient or the network, if you fully employ these elements and principles. On the other hand, there is not always the need for a network meeting, because in a lot of personal crises it might be sufficient to ask for individual help. This is also meant, when we say: "follow the needs of the client" but it seems that the more anxious, irritated or disturbed a person gets, the more important it becomes to gather those people who are in some way involved and caring. Families tend to seclude themselves in moments of severe crisis, though the ground on which they stand is crumbly, slippery, hot and not at all sure for most of them. And here it can be helpful, if more people join in, to bring back some feeling of trust and safety. We have to admit, however, that there is as yet no research on this. As with every therapeutic approach there can arise the question of safety, force or danger for bodily or other kinds of harm. In such cases the way forward seems clear: it must be "safety first", otherwise trust will be destroyed. And then you will make use of anything that might help to prevent damage to persons or things. Close to this, in some way is the fact that a limitation always lies in ourselves. How much experience do we have? How safe do we feel? What do we, as moderators, need to feel safe and secure? This is a very intimate question that everybody has to answer for himself. The safety line is here the element of collaborativity, which opens the door for possible supporters or people who are experts in things we are not.

From isolation to inclusion

Now let us have a closer look at the opportunities and risks of the new approach, viewed from the point of view of all the participants in the field. First let us have a look at the patient or user. Is it a risk for a patient to follow his needs as embedded in his family or network? I cannot know this for certain. Maybe he or she wants to be left alone or undisturbed for some time, and then nothing and nobody will keep them from going into a hospital or a crisis apartment. Is there a risk if, in a network meeting, conflicts suddenly arise, taboos are touched and secrets disclosed? Or what about strong emotions that might erupt suddenly? Yes, there can be a risk, but isn't it then more a question how to deal with it? We see strong emotions as a driving