

# **Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-Year Follow-Up on First Episode Schizophrenia**

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As part of the Need-Adapted Finnish model, the Open Dialogue (OD) approach aims to treat psychotic patients in their home. Treatment involves the patient's social network, starts within 24 hours of initial contact, and responsibility for the entire treatment rests with the same team in inpatient and outpatient settings. The general aim is to generate dialogue to construct words for the experiences in psychotic symptoms. As part of the Finnish national Acute Psychosis Integrated Treatment multicenter (API) project, patients from the initial phase of OD (API group,  $n = 22$ ) were compared historically with patients from the later phase of OD (ODAP group, Open Dialogue in Acute Psychosis,  $n = 23$ ). Then, the API and ODAP groups were compared separately with schizophrenic patients (comparison group,  $n = 14$ ) from another API research center who were hospitalized and received conventional treatment. Hospitalizations in the ODAP group were shorter than in the API group. However, API patients were hospitalized for fewer days, family meetings were organized more often and neuroleptic medication was used in fewer cases than in the comparison group. Also, patients in the ODAP group had

fewer relapses and less residual psychotic symptoms and their employment status was better than patients in the comparison group. The OD approach, like other family therapy programs, seems to produce better outcomes than conventional treatment, given the decreased use of neuroleptic medication.

In the 1980s, the Finnish National Schizophrenia Project (Alanen, 1997; Salokangas, Rääköläinen, & Stengård, 1991) was established to improve care in cases of major mental illness. In this context, Alanen and his colleagues in Turku developed the "Need-Adapted" approach, which emphasized rapid early intervention, planning of treatment to meet the changing and case-specific needs of each patient and family, and adoption of a "therapeutic attitude" in both examination and treatment (meaning an ongoing focus on the therapeutic process rather than on the specific decisions to be made). Treatment was seen as a continuous process involving the integration of different therapeutic methods and the constant monitoring of progress and outcomes (Alanen, 1997; Alanen, Lehtinen, Rääköläinen, & Aaltonen, 1991).

Since the early 1980s in Finnish Western Lapland a further innovation operating within the Need-Adapted approach has been developed: the "Open Dialogue" (OD) approach. The idea behind OD is to provide psychotherapeutic treatment for all patients within their own interpersonal support systems. This is done by generating dialogical communication within the treatment system, and involves mobile crisis intervention teams, patients, and members of patients' social networks in joint meetings. In this article, the OD approach and the study carried out to determine its effectiveness in the treatment of schizophrenia are described. As a research report, this article uses categorical language. Such language does not resonate well with the practice of OD, where establishing firm categories and detecting deficiencies in clients are avoided. More detailed descriptions of OD's theoretical basis and clinical practice are available elsewhere (Seikkula, 2002; Seikkula et al., 1995; Seikkula, Alakare, & Aaltonen, 2001a).

### The Western Lapland Context

The province of Western Lapland (72,000 inhabitants during the study periods, 1992-1997) lies to the north of the Gulf of Bothnia and shares a border with Sweden. The southern part of the region, the most inhabited, is industrialized. Linguistically, ethnically and in religion the population is homogeneous: over 90% are Finnish-speaking Lutheran Finns and live within 60 kilometers of Keropudas Hospital. The incidence of schizophrenia has been extremely high: in the mid-1980s, for example, an annual average of 35 new schizophrenia patients per 100,000 inhabitants was observed, this average being 13/100,000 in the rest of Finland (Salokangas et al., 1991).

As the OD approach was developed, all five mental health outpatient clinics and the hospital with its 30 acute beds established case-specific mobile crisis intervention teams. In principle, all clinical staff members can be called upon to participate in these teams. Therefore, from 1989 through 1998 the inpatient and outpatient staff, numbering about 100 professionals, participated in a 3-year training program in either family therapy or some other form of psychotherapy. Qualification as a psychotherapist by Finnish legal standards was obtained by 75% of the staff.

In a crisis, regardless of the patient's diagnosis, the same procedure is always followed. If hospital treatment is considered, the crisis clinic in the hospital will set up a case-specific team for the crisis meeting, either before the decision to admit for voluntary

admissions, or during the first day after admission for patients referred to the hospital against their own will. In case of a compulsory referral the crisis team expects to be contacted before the referral is made. However, this is not always possible and the treatment starts after the patient has arrived at the hospital. The team usually consists of two or three staff members (e.g., a psychiatrist from the crisis clinic, a psychologist from the patient's local mental health outpatient clinic, and a nurse from the hospital ward). The team takes charge of the entire treatment sequence, whether the patient is at home or hospitalized and irrespective of the expected duration of the treatment. In crises where hospitalization is not considered, the regional mental health outpatient clinics take responsibility for organizing a case-specific team, inviting staff members from different agencies in accordance with the patient's needs (as initially perceived). For instance, in cases of clients involved with several agencies simultaneously, the team may consist of a nurse from the outpatient clinic, a social worker from the social office and a psychologist from the child guidance clinic. The principles governing psychiatric organization have been extended to cover the clinical practice of the entire state social and health care system in the Western Lapland province.

### Treatment Principles of the Open Dialogue Approach

The most critical steps in developing OD were taken (a) in 1984, when treatment meetings began to be organized in the hospital, replacing systemic family therapy (see below); (b) in 1987, when a crisis clinic was founded in the hospital to organize case-specific teams for inpatient referrals; and (c) in 1990, when all the regional mental health outpatient clinics started to organize mobile crisis interventions teams. Seven main principles of treatment have emerged from the various training and research programs undertaken (Aaltonen et al., 1997; Haarakangas, 1997; Keränen, 1992; Seikkula, 1991, 1994):

1. *Immediate Intervention.* The clinics arrange the first meeting within 24 hours of the first contact, made either by the patient, a relative or a referral agency (since 1987). In addition, a 24-hour crisis service exists (since 1992). Providing an immediate response aims to prevent hospitalization whenever possible. In involuntary cases this often means that the compulsory admission can be avoided altogether (Seikkula, 1991). The psychotic patient participates in the very first meetings already during the most intense psychotic period.
2. *Social Network Perspective.* The patients, their families, and other key members of the patient's social network are always invited to the first meetings to mobilize support for the patient and the family. Other key members may represent official agencies, such as the local employment and health insurance agencies to support vocational rehabilitation, fellow workers, or neighbors and friends (since 1987).
3. *Flexibility and Mobility.* These are guaranteed by adapting the therapeutic response to the specific and changing needs of each case, using the therapeutic methods that best fit each case. During the crisis phase no exact plans for future treatment are constructed. After the crisis has calmed, forms and methods of treatment are chosen that best fit the patient's problems and preconditions, and treatment usually continues in a more structured form. The meetings are organized at the patient's home, with the consent of the family (since 1988).
4. *Responsibility.* Whoever among the staff is first contacted becomes responsible for organizing the first meeting, during which decisions about treatment are made. The team then takes charge of the entire treatment process (since 1993-1994).

5. *Psychological Continuity*. As noted, the team is responsible for the entire treatment in both outpatient and inpatient settings. Throughout the process, members of the patient's social network are invited to participate in the meetings. Various methods of treatment are combined and integrated. The treatment of an acute psychotic crisis would seem to require between 2 and 3 years (Jackson & Birchwood, 1996). In line with this notion, in the study here described, 50% of the treatments of schizophrenia patients had ended by the 2-year follow-up (since 1988).
6. *Tolerance of Uncertainty*. Building a relationship in which all parties can feel safe enough to work strengthens this. In psychotic crises, having the possibility for meeting every day at least for the first 10 to 12 days appears necessary to generate an adequate sense of security. After this period, meetings are organized regularly according to the wishes of the family. Usually no detailed therapeutic contract is made in the crisis phase; instead, as a routine part of every meeting, participants discuss whether and if so, when, the next meeting will take place. Meetings are conducted to avoid premature conclusions or decisions about treatment. For instance, neuroleptic medication is not introduced in the first meeting; instead, its advisability is generally discussed for at least three meetings before implementation. Tolerance of uncertainty can be seen as an active attitude among the therapists who aim for a joint treatment process with the patient's network, thus avoiding treatment as a series of mere reactions to events.
7. *Dialogism*. The focus is primarily on promoting dialogue, and secondarily on promoting change in the patient or in the family. The dialogical conversation is seen as a forum where families and patients have the opportunity to increase their sense of agency in their own lives by discussing the patient's difficulties and problems (Haarakangas, 1997; Holma & Aaltonen, 1997). A new understanding is built up in the area between the participants in the dialogue (Andersen, 1995; Bakhtin, 1984; Voloshinov, 1996). The team's aim in constructing the dialogue is to follow the themes and the way of speaking that the family members are used to. The latter two principles (tolerance of uncertainty and dialogism) have been established as working guidelines since 1994-1996 (Seikkula et al., 1995).

During the meetings the participants discuss various issues associated with the actual problem. All management plans and decisions are made with everyone present. According to Alanen (1997), the meeting serves to gather information about the problem, to plan treatment and on the basis of the diagnosis made in the course of the conversation, to make all decisions needed and to generate a psychotherapeutic dialogue. The starting point for treatment is the language of the family: how family members have, in their own language, named or defined the patient's problem. Problems are seen as social constructions specific to each particular conversation (Bakhtin, 1984; Gergen, 1994, 1999; Shotter, 1993). Each person has his/her own voices in constructing the problem and, as Anderson (1997) has noted, listening to others becomes more important than any specific way of interviewing. In the case of a psychotic patient, it seems important to accept the psychotic hallucinations or delusions of the patient as one voice among others. In the beginning, hallucinations and delusions are not challenged, but the patient is encouraged to tell more about his/her experiences.

An important idea behind OD is to integrate different methods of treatment in a single treatment process. The patient can have individual or other therapies (e.g., art therapy, group therapy, occupational therapy) and the family can meet for family therapy. In cases of psychotic crisis, psychiatric and vocational rehabilitation are emphasized from

the very beginning. For instance, special 2-month vocational rehabilitation courses can be organized jointly with the local state employment and health insurance agencies. Treatment usually starts with intensive meetings during the heaviest phase of the crisis after which individual psychotherapy and other types of psychotherapy and rehabilitation are used in addition to the meetings. In the final phase of treatment various forms of psychological and vocational rehabilitation receive more emphasis than the treatment meetings, although these will usually continue throughout the entire process.

### **"Taking Care of Her Studies": A Case Study**

The processes and principles of OD just described are illustrated in the following case vignette. The patient participated in the research project described in this article.

Liisa was 16 years old when, during her first year in vocational school, she began to show signs of problems to her parents. She became easily irritated and isolated herself in her room during weekends at home. She continued to attend school in another city, where she also had a flat, but in April her behavior seriously worsened. She stopped taking care of her hygiene, her talking transformed to a mumble and her eyes were turned toward the sky. She also had peculiar body movements, such as rocking. Her parents were unable to have any proper contact with her and took her to the emergency room of the local primary care center. She stayed overnight in the ward and the following day a team consisting of a psychiatrist from the psychiatric hospital, a nurse and a psychologist from the local psychiatric outpatient clinic met her at the primary care center together with her parents. It was decided that Liisa would return home and a home visit was organized. In several successive meetings every day or other day, Liisa usually sat with her knees under her jaws, eyes turned toward the sky. When asked a question, she did not answer, only some mumbling was heard. Her parents were very worried and they both cried a lot. Her brother came home from his study place to provide support. In many meetings, neuroleptic medication was considered, but Liisa's parents did not like that idea and the psychiatrist wanted to proceed carefully. After several meetings, a slight progress was noted in the sense that Liisa started to sleep better and also started to give short answers to the team member's questions.

During the summer, after 3 months' treatment, a 5-week break occurred in the meetings, as instructed by the family. New meetings were organized and after 6 months, surprising everyone, Liisa announced that she was going to return to her studies. Both parents and team members were suspicious and did not think that Liisa could cope with her studies and living away from home. After discussing this during two meetings, the team approved Liisa's initiative and proposed to hold network meetings at Liisa's school. In two meetings, attended by Liisa and her family, the school principal, Liisa's closest teacher, and the school nurse, participants discussed what support was needed by Liisa. Although the team proposed continuing the treatment meetings, the family disapproved, saying that after Liisa had moved away, there was no sense for these meetings to continue. Altogether, 20 treatment meetings were held.

At the 2-year follow-up the entire family was seen. Liisa was no longer psychotic and she was about to take her exam from the vocational school. Her parents said that they were constantly worried although nothing alarming had occurred. Liisa had shown hints of psychotic problems for about a year, but none had appeared. When asked about their experiences, the parents were satisfied that Liisa had not been hospitalized, although in the beginning it was a rather difficult situation for the family. They were also satisfied with not having used neuroleptic medication. Liisa used anxiolytic medication for 3 months in the beginning to help her sleep. In the process they had not liked some circular questions asked by one member of the team, which especially the mother had felt increased her guilt concerning Liisa's psychosis.

The family was seen again after 6 years. Liisa said that she had taken another profession, as she was unable to find a job. She had not had any psychotic symptoms, although every now and then she felt anxiety. She had started to think about the possibility of starting individual psychotherapy to clarify to herself what had happened during her crisis. Her parents said that their life had become much more serious than before; her mother even stated that "laughter has disappeared from our life." They felt that it would have been good to have some meetings, for instance once a year, to meet with the team and to tell of their life.

Most main principles of OD were applied in this case. Treatment started within 24 hours after the first contact from primary care, and the team immediately took the responsibility for the entire process and guaranteed psychological continuity. The idea of mobilizing the social network was applied, and that seemed to give positive results, too. The sadness of the family afterwards may describe some problems in dialogism; although the family did not want further treatment meetings, the team did not generate dialogue, in which other voices of the situation had been heard as well. Tolerance for uncertainty seemed especially important for the team during the first 3 months. Although Liisa was severely psychotic during this phase and the team on several occasions considered the possibility of neuroleptic medication to decrease the psychotic symptoms more rapidly, team members respected the family's wish and continued to meet intensively to share the difficult situation, thus supporting both the family and Liisa.

### **Open Dialogue and Other Psychosocial Approaches in Psychosis**

Certain ideas from systemic family therapy (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978, 1980), especially of circular reasoning rather than linear causality, and positive connotation, are also elements in OD. However, OD does not focus on the family system or even communication within the family system (Boscolo & Bertrando, 1993). The aim in OD is not "to give an impulse to change the fixed logic of the system by introducing a new logic" (Boscolo & Bertrando, 1998, p. 217), but to create a joint space for new language, where things can begin to have different meanings, as Anderson and Goolishian (1988) and Anderson (1997) have described it. In OD therapists do not focus on ways of behaving and communicating that may be behind manifest behavior.

In OD, the therapist focuses on the spoken words in order to build up new words and a new language. This is in line with the ideas of social constructionist writers (Gergen, 1994; Gergen & McNamee, 2000; Shotter, 1993). White (1995) has described narrative therapy with psychotic patients and Holma and Aaltonen (1997, 1998) have conducted a research project on narrative therapy with first episode patients. Both OD and narrative therapies share the social constructionist view of reality, but differ in their understanding of the authorship of new narratives. Narrative therapists aim at reauthoring the problem-saturated story, whereas dialogic approaches aim at moving from stuck monologues to more deliberating dialogues (Smith, 1997). In narrative therapy the narrative has an author; in dialogical therapies the new narrative is co-created, in the space between the participants.

OD and psychoeducational programs (Anderson, Hogarty, & Reiss, 1980; Falloon, 1996; Falloon, Boyd, & McGill, 1984; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996) share a view of the family as an active agent in the process. Families are seen neither as the cause of psychosis nor as an object of treatment, but as "competent or potentially competent partners in the recovery process" (Gleeson, Jackson, Stavely, & Burnett, 1999, p. 390). The two approaches differ in their theoretical assumptions about

psychosis. OD emphasizes action during the most intense crisis phase and the process quality of building treatment plans. From the perspective of the stress-vulnerability model (Zubin & Spring, 1977), psycho-educational approaches most often aim at determining an exact diagnosis and choosing the treatment program according to that diagnosis (McGorry, 1999). Either in individual session or multiple-family groups, families are involved in psychoeducation to improve communication in order to prevent relapses and to enhance remission (Chadwick, Birchwood, & Trower, 1996; Eckman et al., 1992; Falloon et al., 1984; Gleeson et al., 1999; Hogarty et al., 1997; Liberman & Corrigan, 1993; Liberman & Green, 1992; McFarlane et al., 1995a, 1995b; Mueser, Wallace, & Liberman, 1995; Perris & McGorry, 1998). Many of these programs see psychosis as symptoms of an illness, whereas in OD psychotic behavior is seen as one possible answer in the present dialogue. In OD, a uniform explanation of psychosis is not given, but the discussion is based on the family's way of discussing the problem.

### **Evaluation of Effectiveness in Schizophrenia Outcome Studies**

The study reported in this article aimed to clarify the effectiveness of OD in treatment of first episode psychosis. In contrast to efficacy, a term used in randomized control trials where variables are controlled to better determine the cause of the observed results, effectiveness is usually used in quasi-experimental designs in which no exact hypothesis concerning causes is made (Pinsof & Wynne, 2000). Most studies of psychosocial treatment in first-episode psychosis have dealt with family psycho-educational, behavioral and cognitive therapies (Bustillo, Lauriello, Horan, & Keith, 2001; Penn & Mueser, 1996). The second generation studies (Fadden, 1998; Jackson & Birchwood, 1996) have focused on preventing schizophrenia by early intervention in the prodromal phase (Edwards & McGorry, 1998; Falloon, 1992; Garbone, Harrigan, McGorry, Curry, & Elkins, 1999; Larsen, Johannesen, & Opjordsmoen, 1998; Yung et al., 1998).

The most frequently employed outcome measures have included number of relapses, ratings of psychotic symptoms and social functioning, employment status, and hospital days (Keefler & Koridar, 1994; Liberman & Corrigan, 1993; Loebel et al., 1992; McGorry et al., 1996). Over the century, 40% of schizophrenia patients were considered to have improved after follow-ups averaging 5.6 years, the average rate of a favorable outcome declining during the last decades to about 36% (Hegarty, Baldessarini, Tohen, Waternaux, & Oepen, 1994). In the advanced psychosocial programs, Lieberman (1996) found that 86% of patients seemed to recover from psychosis during the first year, but 78% of these relapsed at least once thereafter. For all psychotic patients, relapses during the first and second year of treatment have decreased to 14% to 35% (Lieberman, 1996; Linszen, Lenior, de Haan, Dingemans, & Gersons, 1998; McGorry et al., 1996); however, risk of relapse increases if the continuation of treatment is not guaranteed (Linszen, Dingemans, Scholte, Lenior, & Goldstein, 1998). Family psycho-education and social skills training became less effective against late relapse in the second year after discharge (Hogarty et al., 1997). Over half of patients were found to be living on disability allowance after 2 years (Gupta, Andreasen, Arndt, & Flaum, 1997; Shepherd, 1998), whereas in the small-sample studies by Lehtinen (1993) and Cullberg, Thowen, Abb, Mesterson, and Svedberg (2000), this figure was only about 20%. The number of hospital days has decreased to approximately 25 to 40 during the first year of treatment (Cullberg et al., 2000; Lehtinen, 1993; McGorry et al., 1996). Where neuroleptics were not started at the outset, they were later seen as necessary in about half of all psychotic patients (Cullberg et al., 2000;

Lehtinen, Aaltonen, Koffert, Rökköläinen, & Syvälahti, 2000). Employment status was better when placebo was used instead of neuroleptic medication (Johnstone, Macmillan, Frith, Benn, & Crow, 1990).

## STUDY DESIGN

The effectiveness of OD was explored in the context of the Finnish national multicenter Acute Psychosis Integrated Treatment (API) project, which ran from April 1, 1992, through December 31, 1993, with a follow-up of 2 years from the beginning of treatment, under the direction of the National Research and Development Center for Welfare and Health (STAKES) in conjunction with the Universities of Jyväskylä and Turku (Lehtinen et al., 1996, 2000). Western Lapland was one of the six research centers. All first-episode cases of nonaffective psychosis (DSM-III-R) were included. After December 31, 1993, it was decided to continue the project at the local level, to sustain the results of the API period as well as to produce a further improvement in the results. The continuation period, named the Open Dialogue Approach in Acute Psychosis (ODAP), ran from January 1, 1994, through March 31, 1997. The local ethical committee gave permission for the study, and every patient was asked to give his/her consent for inclusion.

One aim of the API project was to provide a better information base on which to develop appropriate medication practices as an element of psychotherapeutic treatment. Three research centers—including Western Lapland—sought to avoid starting the use of neuroleptic medication during the early stage of treatment. The results from these three centers were compared with results from three others where neuroleptics were used in the traditional way. A specific procedure for deciding whether or not to use neuroleptic medication was planned. During the first 3 weeks, benzodiazepines were used in the event of need for medication and, after this, if there was no reduction in the psychotic symptoms or in the social behavior of the patient, neuroleptic medication was considered.

The study design was not specifically planned to evaluate the effectiveness of OD, since it was a part of a multicenter project with more general aims. Because the study was not planned as a randomized trial to evaluate a treatment method, but was a descriptive study of the entire treatment system in single catchment area, no conclusions should be drawn as to the efficacy of OD compared to conventional treatment.

This report describes results for the three different groups of schizophrenia patients, two in Western Lapland (API and ODAP groups) and one comparison group. The system of treatment had already been reorganized during the API period, but it was not until the ODAP period (from 1994 onward) that it became possible to transform the content of the psychotherapy. The staff had enough training to establish responsibility, tolerance of uncertainty and dialogism as the guiding principles of the treatment meetings. In comparing the API and ODAP periods the differences between treatment methods are not categorical, but in the ODAP period treatment was built on the foundations of the work done during the API period. It had become possible to apply the psychotherapeutic elements in a more systematic way and the therapists were able to make use of the experiences of the treatment of psychotic problems gained during the API period. The comparison group came from another API project center in the city of Jyväskylä. Ethnically, this region is quite similar to that of Western Lapland. The population is homogenous, over 90% Finnish, and the main occupational fields are services, manufacturing and



education. This project center organized the treatment in a more institutionalized way. First-episode psychotic patients were referred to the local psychiatric hospital by local outpatient clinics or by a general practitioner. In the ward, family meetings were organized within 24 hours after admission and neuroleptic medication was prescribed at the outset. In some cases, members of the outpatient staff were able to participate in the meetings in the hospital, but for the most part the hospital team took charge of the process. After the inpatient period, patients were referred to the outpatient clinic for after-care, which meant that the staff members changed. The research procedures were the same in the comparison group, the inclusive periods being the same with the API study group in Western Lapland.

### SAMPLES

In Western Lapland, complete data were available for 34 API patients, of whom 22 were diagnosed as having schizophreniform or schizoaffective psychosis or schizophrenia, according to DSM-III-R criteria (American Psychiatric Association, 1987); and 44 ODAP patients, of whom 23 were diagnosed as having schizophreniform or schizoaffective psychosis or schizophrenia. Disregarding three dropouts at the outset, the data cover all psychotic patients in Western Lapland during both study periods (Table 1).

Although the comparison group contained 21 psychotic patients, it was found in performing the comparison that only the schizophrenic group ( $n = 14$ ) was comparable to both Western Lapland groups (see Table 2). In all three groups patients diagnosed as having milder forms of psychosis, such as Psychosis NOS and brief psychotic episodes, were excluded. In the comparison group, one patient was diagnosed as having psychotic depression and was excluded. The analysis was done by (1) comparing the comparison group ( $n = 14$ ) to the API ( $n = 22$ ) and the ODAP ( $n = 23$ ) groups in order to compare the effectiveness of OD to conventional treatment; and (2) conducting a historical comparison between the API and ODAP groups to determine if the original API results persisted beyond the original study as well as to see if further changes or improvements were forthcoming as the approach was transformed into a more consistent dialogic approach by the use of properly trained staff.

TABLE 1. Reasons for Exclusion From the Study During the API and ODAP Periods in Western Lapland

	API (1 Apr. 1992 to 31 Jan. 1993)	ODAP (1 Jan. 1994 to 31 March 1997)
Treatment started	39	54
Refused to participate	1	2
Not reached at follow-up	2	2
Excluded because of earlier treatment	0	3
Treatment started in a unit outside OD	1	1
Deceased	1	2
Total	34	44

**TABLE 2. Characteristics and Premorbid Adjustment of the Schizophrenia Patients in the Three Groups at Baseline**

	API group n = 22	ODAP group n = 23	Comparison group n = 14	$\chi^2$	df	p
Age range (yrs.)	19-38	17-43	18-42			
Mean	27.6	27.8	27.7	F (2,57 = 0.030)		ns
Sex				0.765	2	ns
Male	12	16	8			
Female	10	7	6			
Marital status				4.166	6	ns
Single	14	17	8			
Married, living together or divorced	8	7	6			
Employment status				10.691	8	ns
Studying	4	4	1			
Working	10	11	10			
Unemployed	2	5	2			
Passive	6	3	1			
DSM-III-R diagnosis				3.026	2	ns
Schizophrenia	13	19	8			
Schizophreniform	9	4	6			

"Unemployed" means had been working during the last 2 years, but presently unemployed and job-seeking. "Passive" means being unemployed without searching for a job.

The evaluations of all patients were carried out at the outset of treatment and 2 years thereafter. At the outset, no significant differences appeared in age, sex, marital or employment status, or in diagnosis, and hence the groups can be regarded as comparable with each other (Table 2).

Psychiatric diagnosis was made in two phases. After the first meeting, the team, jointly with the responsible chief psychiatrist (author B. A.), formulated an initial hypothesis and after 6 months, having also interviewed the patients individually, made a final diagnosis. The same procedure was followed in the comparison group, where an experienced psychiatrist, who was not involved in the treatment processes, made the diagnosis. An experienced psychiatrist from outside the two regions served as a rater to test the reliability of the diagnosis. The level of diagnostic consistency of the schizophrenia diagnosis was 78% in the Western Lapland group and 80% in the comparison group ( $\kappa = .453$ ,  $p = .002$ ).

## METHODS

The main sources of data were (a) process variables, that is, number of hospital days, number of family meetings, use of neuroleptic medication and individual psychotherapy, and (b) outcome variables, that is, number of relapses (defined as making a new contact for treatment after terminating the original treatment, or an intensification of existing treatment in the form of more intense meetings because of new psychotic or other symptoms); whether the patient was employed, studying, job-seeking or living on a disability

allowance; and the ratings of mental state by the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962), the General Assessment of Global Functioning (GAF; Endicott, Spitzer, Fleiss, & Cohen, 1976), and by a 5-category subscale of the Strauss-Carpenter Rating Scale for psychotic symptoms (from 0 = no symptoms to 4 = continuous prominent symptoms; Opjordsmoen, 1991; Strauss & Carpenter, 1972). The ratings were jointly done, using a consensus conference method, by researchers J. S. and B. A. who, as researchers, were not involved in the specific treatment process, except for one case in the API group and one case in the ODAP group where both researchers were involved as responsible therapists and were thus unable to maintain the stance of external observers. (Both cases were extremely difficult, with both patients receiving the most severe ratings in all instruments used, and all possible resources were mobilized for their treatment). The same rating procedures were followed in the comparison group by authors J. H. and A. R.

The research procedure includes some substantial limitations. First, the raters could not be blind to the treatment the patient received, which increased the risk of bias to perceive more favorable outcomes. Second, the raters were different in both study centers, which decreased the reliability of the ratings. These problems were handled by having a joint meeting of the researchers of both centers at the 2-year follow-up. Based on the patients' records, the researchers at each center rated the patients from the other center. After this, in a consensus conference the four researchers decided the joint ratings. The results of ratings should be interpreted cautiously, whereas the variables based on the registration of the treatment incidents and on the official statistics such as employment status include more reliable information.

The statistical analysis was conducted as pair comparisons using the Pearson Chi-square in crosstables, a one-way analysis of variance (ANOVA) and a *t*-test for the comparison of the means of independent groups, and a repeated measures ANOVA to compare the change in ratings between the three groups. Because API and comparison groups had the same inclusion period (April 1, 1992, to January 31, 1997), they were compared first. Only when no differences were observed between API and comparison groups did researchers look for differences between ODAP and comparison group.

## RESULTS

### Comparison of the Groups at Follow-Up

**Differences With Comparison Group.** Because of the differences in the approaches used, it was predictable that the process variables such as hospitalization ( $p < .01$ ) and neuroleptic medication ( $p < .001$ ) were more often used in the comparison group than in the API group (Tables 3 and 4). The Comparison had significantly fewer family meetings than the API group ( $p < .001$ ). The number of meetings varied from 6 to 55 in the API group, from 0 to 99 in the ODAP group and from 0 to 23 in the comparison group. Individual psychotherapy was applied to about the same extent in each of the three groups.

At least one relapse occurred in 31% of the API, in 24% of the ODAP and in 71% of the comparison group. This difference was significant between the API and comparison group ( $p < .05$ ; Table 5). The ODAP patients had fewer residual psychotic symptoms than comparison group patients ( $p < .05$ ). The employment status of the ODAP patients was better than in the comparison group ( $p < .001$ ). In the latter group, 30% of patients were studying, working or job-seeking, versus 83% in the ODAP group.

**TABLE 3. Frequencies in Treatment Process Variables in the Three Groups at the 2-Year Follow-Up, a Pair Comparison**

	API group n = 22	ODAP group n = 23	Comparison group n = 14	$\chi^2$	df	p	Power
Use of neuroleptics							
Started	8	8	14	14.5	2	< .001 <sup>a</sup>	1.00
Ongoing	5	4	10	8.35	2	< .05 <sup>a</sup>	0.74
Individual psychotherapy							
Yes	12	11	8				
No	10	12	6	0.49	2	ns	

<sup>a</sup> $\chi^2$  between API and comparison groups only.

**TABLE 4. Means of Treatment Process and Outcome Variables in the Three Groups at the 2-Year Follow-Up, t-Test Pair Comparison**

	API group n = 22	ODAP group n = 23	Comparison group n = 14	t-value	df	p	$\eta^2$
Hospitalization days							
Mean	35.9	14.3	116.9	3.29	34	< .01 <sup>a</sup>	.242
SD	44.0	25.0	102.2				
Number of family meetings							
Mean	26.1	20.1	8.9	4.291	34	< .001 <sup>a</sup>	.351
SD	14.1	20.6	6.2				
BPRS score							
Mean	32.3	24.9	26.5	2.532	40	< .05 <sup>b</sup>	.144
SD	13.7	5.2	7.1				

BPRS is a 19-item scale, each item rated 1-9.

<sup>a</sup>t-test for independent samples between API and comparison groups.

<sup>b</sup>t-test for independent samples between API and ODAP groups.

**TABLE 5. Frequencies of Outcome Variables in the Three Groups at the 2-Year Follow-Up**

	API group n = 22	ODAP group n = 23	Comparison group n = 14	$\chi^2$	df	p	Power
Number of relapsed patients	8	6	10	4.21	1	< .05 <sup>a</sup>	.39
Employment status							
Studying or working	13	15	3				
Unemployed	1	6	3				
Disability allowance	8	2	8	10.36	8	< .001 <sup>b</sup>	.82
Residual psychotic symptoms							
0-1	14	19	7	4.43	4	< .05 <sup>b</sup>	.41
2-4	6	4	7				

"Unemployed" means to have been working during the last 2 years, but at the moment unemployed and job-seeking.

<sup>a</sup> $\chi^2$  between API and comparison groups.

<sup>b</sup> $\chi^2$  between ODAP and comparison groups.

**Differences Between API and ODAP Groups.** In the API and ODAP groups, similar numbers of patients received neuroleptic medication. Treatment dropout rates were also similar (14%-16%). ODAP group patients had significantly fewer hospital days. We noted a slight decrease in relapse rate during the ODAP period. API patients had a higher BPRS score ( $p < 0.05$ ; Table 4), probably accounted for by two patients in the API group with an especially high score; both these patients were on neuroleptic medication.

**Repeated Measures of Variance With Time and the Three Groups.** To determine differences in the change of GAF rating, psychotic symptoms rating and employment status, the three groups were compared simultaneously in repeated measures ANOVA (Table 6). The smallest improvement in the GAF rating was found in the comparison group (Table 7;  $p < 0.001$ , the interaction effect), as was the smallest decrease in psychotic symptoms (Table 7;  $p < 0.01$ ). Employment status declined in the comparison group, remained the same in the API group, and slightly improved in the ODAP group due to one more case located in the category of studying, working, or job-seeking at follow-up (Table 7;  $p < 0.05$ ). In the historical comparison, both the improvement in GAF

**TABLE 6. Repeated Measures Analysis of Variance With Time (1,2) and Groups (1,2,3) as Factors**

	API Groups	ODAP Group	Comparison Group	Total
GAF rating				
Baseline	3.2 (SD .80)	2.8 (SD .64)	4.2 (SD .89)	3.3 (SD .63)
2 year follow-up	5.8 (SD 1.6)	5.7 (SD 1.3)	4.9 (SD 1.6)	5.6 (SD 1.5)
Psychotic symptoms				
Baseline	3.5 (SD .51)	3.3 (SD .69)	3.2 (SD 1.9)	3.3 (SD .63)
2 year follow-up	0.9 (SD 1.1)	.6 (SD .99)	1.9 (SD 1.5)	1.0 (SD 1.3)
Employment status				
Baseline	1.4 (SD .49)	1.3 (SD .48)	1.3 (SD .47)	1.3 (SD .48)
2 year follow-up	1.4 (SD .49)	1.1 (SD .29)	1.6 (SD .51)	1.3 (SD .46)

Note. Employment status variable was dichotomized: 0 = studying, working, or job-seeking; 1 = passive or living on a disability allowance.

**TABLE 7. Repeated Measures Analysis of Variance With Time (1,2) and Groups (1,2,3) as Factors (n = 60)**

Scale	F	df	p
GAF rating	97.51	1,56	< .001 <sup>a</sup>
	0.64	2,56	ns <sup>b</sup>
	9.12	2,56	< .001 <sup>c</sup>
Psychotic symptoms	186.52	1,55	< .001 <sup>a</sup>
	4.31	2,55	< .05 <sup>b</sup>
	7.12	2,55	< .01 <sup>c</sup>
Employment status	0.09	1,56	ns <sup>a</sup>
	2.28	2,56	ns <sup>b</sup>
	3.30	2,56	< .05 <sup>c</sup>

Note. Employment status variable was dichotomized: 0 = studying, working, or job-seeking; 1 = passive or living on a disability allowance.

<sup>a</sup>Time main effect.

<sup>b</sup>Group main effect. <sup>c</sup>Time (1,2) by groups (1,2,3) interaction effect.

and decrease in psychotic symptoms were the same in the API and ODAP groups. Concerning employment status, the ODAP group tended to have a better outcome, but the difference was not significant.

## DISCUSSION

Comparison of the Western Lapland API and ODAP groups to the comparison group showed that in the first two groups hospitalizations were shorter and neuroleptics were used in fewer cases. In the comparison group fewer family meetings were held and patients had more relapses. Employment status improved in the ODAP group. With regard to the change in psychological status, both groups in Western Lapland showed a greater improvement in the GAF rating and a greater decrease in psychotic symptoms. In BPRS a difference was found between the Western Lapland API and ODAP groups.

### Limitations of the Study

Before commenting on the results, the shortcomings of the data and the limitations of the study design should be noted as these affect the conclusions that can be drawn. Psychosis, and in particular schizophrenia, is a rare problem and in a small catchment area the selection of cases is susceptible to the effects of many unforeseen factors. This risk especially concerns the comparison group, which was selected over a 21-month period. Thus the patients in the comparison group could have had more severe symptoms than is usual in that health district. In small samples simply a single patient being moved between categories may affect statistical significance. We tried to reduce the influence of chance events influencing sample selection from this small population in Western Lapland both by conducting a historical comparison and by having a comparison group with conventional treatment. On the other hand, selecting from a small catchment area is also an advantage in the sense that it is possible to control for those patients who were excluded for some reason, since the treatment is the only kind available for psychiatric patients.

The other problem comes from the fact that the design was a naturalistic study. Utilizing a historical comparison restricts the conclusions to describing the differences in the effectiveness between study groups and does not allow making causal statements. Many variables were not controlled for and may have affected the outcomes. In a historical comparison, criteria for including patients into the treatment may change, even within the same organization, although in the Finnish context the psychiatric units have to take care of all patients. Staff members may change and bring with them personal variables that are uncontrolled. The social, economic, and psychological situation of the patients may vary, producing different types of psychiatric problems. The researchers performing the ratings were involved in developing the OD approach, which raises the risk of bias. To minimize this kind of bias, more objective data on the use of treatment and employment status were included, and the ratings of psychological status and symptoms should be seen as confirming the validity of this information.

### Outcome Differences

Relapses have commonly been seen as a salient indicator of outcome. In the comparison group relapses occurred in surprisingly many cases, which may be due to the discontinuation of treatment after the initial inpatient phase. This was also noted in the Linzen,

Dingemans, and colleagues (1998) project. In Western Lapland the interaction between the team and the social network around the patient seemed to develop in a more positive direction. When the patients succeeded in returning to active employment or study, they also had less psychotic symptoms, and vice versa. In this sense the outcome of the ODAP group is especially interesting, as an improvement in employment status actually occurred during the treatment period.

It can be suggested that the differences in the outcomes found here were related to the differences in the treatment. The most noteworthy difference concerned the number of family meetings. In Western Lapland the patient's family and social network participated closely in the treatment from the very beginning. The length of treatment and the number of treatment meetings varied considerably, but individual psychotherapy was used in about half of the cases, as in the comparison group as well. In the latter, families also participated in the inpatient phase, but not to the same extent as in the other two groups. After the inpatient phase the therapists were changed. As far as differences in employment status are concerned, it is possible that whereas in Western Lapland members of the patient's social network were able to participate fully in the meetings, in the comparison group the meetings were more, if not entirely, focused on the patient's families. The active involvement of the social network decreased the gap between the patient and the family and in this way could have helped support the patient in returning to an active social life. The short or no hospitalizations in the API and ODAP groups supported this. Return to work and to studying was encouraged, which means that periods on a disability allowance became shorter. In the patient's social network an important role was played by various agencies, for example, for vocational rehabilitation, which were able to assist directly in building up possibilities for vocational rehabilitation and training. These remarks on the outcome are suggestions for further research, not causal conclusions.

### Limitations of the Open Dialogue Approach

A problem in instituting OD may be that the treatment is very much centered around the team, which takes responsibility for the continuity of treatment. It is an administrative and therapeutic challenge to commit oneself to teams that may end up working together for several years. A team may consist of two or three staff members who will meet approximately 25 times, mostly during the first year of treatment. In several cases more than 50 meetings were organized over 2 years. Changes in the team composition threaten continuity.

During the ODAP period, 52 staff members either completed or were participating in the 3-year training program in family therapy. This training is especially valuable in enhancing the tolerance of uncertainty during treatment. Open dialogue is far less structured than many other psychosocial models, but its outcomes seem comparable. The outcomes do not, however, occur automatically, but presuppose specific psychotherapeutic training and experience of team members in working with psychotic patients and their families. The expertise of the staff is not primarily focused on the setting up of specific therapeutic programs or training courses, but, instead, on generating dialogue in the extreme situation of a psychotic crisis. This kind of work presupposes psychotherapeutic skills, for which we believe training is a necessity.

### Use of Neuroleptic Medication

Whether or not neuroleptics were used at the outset, patients seemed to recover: 79% of the ODAP patients had no or mild residual psychotic symptoms at follow-up. Postponing the start of neuroleptic medication and, in 64% of cases not using any neuroleptic medication, did not seem to increase the number of relapses and dropouts. Relapse has been seen as the biggest risk in nonmedication studies (Carpenter, 1997; Wyatt, 1997). The 2-year relapse was 24% in the ODAP group and 31% in the API group. The number of relapses among all psychotic patients has varied between 14% and 35% in psychosocial programs (Bustillo et al., 2001; Hogarty et al., 1997). One of the lowest relapse rates is that reported by Lijnzen, Dingemans, and associates (1998). In their time-limited project, 16% to 20% of patients relapsed during the first year, but problems emerged after discontinuing the project and relapses rose to 64% by the 2-year follow-up. In the present study, we believe that the low proportion of dropouts (14% API, 16% ODAP) was probably related to most of the crisis interventions being conducted at the patient's home.

This study does not allow any firm conclusions to be drawn regarding the use of neuroleptic medication in general. We do not know how patients with mild psychotic symptoms at the 2-year follow-up would have done had they taken neuroleptics at the outset of treatment. The findings regarding employment status resemble those from one of the few placebo trials on neuroleptic medication. In the Johnstone, Crow, Johnson, and Macmillan (1986) and Johnstone and colleagues (1990) studies, patients had a better occupational outcome on placebo than on neuroleptics. In this study, during the ODAP period, 83% of patients were either studying, working, or job-seeking, while 34% of all the patients had used neuroleptics at some point during their treatment. The question can be asked whether neuroleptic medication should be used in the early phase of treatment or not to distinguish those patients who can genuinely benefit from it from those patients whose chance of an active social life can be put at risk by it. According to the present results, postponing the start of neuroleptics did not increase the risk of a poorer outcome. In fact, in another study (Seikkula et al., 2001b) it was found that using neuroleptic medication was related to a poor outcome. This question needs further clarification.

### The Cost-Effectiveness of the Open Dialogue Approach

As developed in Western Lapland, OD is not an expensive but a cost-effective approach for the community. It has meant moving hospital personnel to crisis intervention work in outpatient settings. Although no analysis of the cost-effectiveness of OD has been conducted, it is useful to examine OD in the context of the financing of state health care in Finland. Because of the deep recession of 1991, there were drastic cuts nationwide in the resources available to psychiatry. Budgets for psychiatric services in Western Lapland decreased by 33% from the end of the 1980s through the mid-1990s, and became the lowest among health districts in Finland. Although professionals viewed these cuts in funding as unfair and threatening, especially to the treatment of long-term patients, the decrease did not affect the quality of the treatment of first episode psychotic crises, as this study demonstrates. Compared to many time-limited research projects, the advantage of the Western Lapland model is that the OD approach has been incorporated into the state psychiatric system and thus the end of the research project constitutes no threat to the continuity of the treatment of psychotic patients.



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