OPEN DIALOGUE IN PSYCHOSIS I: AN INTRODUCTION AND CASE ILLUSTRATION

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As a social construct, our approach to work with severely disturbed psychiatric patients in crisis, termed Open Dialogue (OD), begins treatment within 24 hours of referral and includes the family and social network of the patient in discussions of all issues throughout treatment. Treatment is adapted to the specific and varying needs of patients and takes place at home, if possible. Psychological continuity and trust are emphasized by constructing integrated teams that include both inpatient and outpatient staff who focus on generating dialogue with the family and patients instead rapid removal of psychotic symptoms. The main principles are described, and a case is analyzed to illustrate these.

In the 1980s, the Finnish National Schizophrenia Project began an ambitious study to improve the care of major mental illness. In this context, Alanen and his colleagues in Turku developed the Need-Adapted approach, which emphasized: (1) rapid early intervention; (2) treatment planning to meet the changing and case-specific needs of each patient and family; (3) attention to therapeutic attitude in both examination and treatment; (4) seeing treatment as continuous process, integrating different therapeutic methods; and (5) constantly monitoring treatment progress and outcomes (Alanen, 1997; Alanen, Lehtinen, Räkköläinen

& Aaltonen, 1991). Our group in Finnish Western Lapland, operating within the Need-Adapted approach, has developed a further innovation, which we term Open Dialogue (OD). Our model of intervention organizes psychotherapeutic treatment for all patients within their own particular support systems, and attends to the forms of communication used within treatment units made up of mobile crisis intervention teams, patients, and their social networks. We have found that facilitating dialogic communication within the treatment systems can be an effective approach. In this article, we describe our approach to treatment, which draws upon and implements social constructionist and constructivist principles.

The province of Western Lapland (72, 000 inhabitants) lies to the north of the Gulf of Bothnia and shares a border with Sweden. The southern part of the region, where the main part of the population lives, is industrialized. Linguistically, ethnically, and religiously the population is homogeneous. Over 90% are Finnish-speaking Lutherans and 90% live within 60 kilometers of Keropudas hospital. The incidence of schizophrenia has been extremely high, with an average of 35 new schizophrenia patients per 100,000 inhabitants in the mid-1980s. With the development of the new family and network centered treatment system that level declined to 7/100,000 by the mid-1990s (Aaltonen, et al., 1997).

The development of the new approach started in the early 1980s at the time of the Finnish National Schizophrenia Project. By the middle of the 1990s psychotherapeutic treatment was being organized for all patients within their own particular social support systems. Currently all five mental health outpatient clinics and Keropudas hospital with its 30 acute beds organize case-specific mobile crisis intervention teams. All staff members can be called upon to participate in these teams according to need. To achieve this, all members of staff (both inpatient and outpatient staff), totaling about 100 professionals, participated in either a three-year family therapy training program or some other form of psychotherapy training between 1989 and 1998. Seventy-five percent of the staff obtained qualification as psychotherapists in accordance with Finnish law.

In a psychiatric crisis, regardless of the specific diagnosis, the same procedure is followed in all cases. If it is a question of possible hospital treatment, the crisis clinic in the hospital will arrange a treatment meeting, either before the decision to admit for voluntary admissions or during the first day after admission for compulsory patients. At this meeting, a tailor-made team, consisting of both outpatient and inpatient staff, is constituted. The team usually consists of two or three staff members (for instance a psychiatrist from the crisis clinic, a psycholo-

gist from the patient's local mental health outpatient clinic, and a nurse from the ward). The team then takes charge of the entire treatment sequence, regardless of whether the patient is at home or in the hospital and irrespective of how long the treatment period is expected to last. In other types of crisis, where hospitalization is not considered, the regional mental health outpatient clinics take the responsibility by organizing a case specific team and inviting members of the different facilities that are relevant to the patient. For instance, the team for multiagency clients may consist of one nurse from the outpatient clinic, one social worker from the social office and one psychologist from the child guidance clinic. The principles of this organization have been embedded in the entire state social and health care network in the province. In fact, the same concept also is applied in other than psychiatric and social crisis, for example in organizing debriefing in different types of posttraumatic situations.

Several action research studies have been conducted to evaluate the effectiveness of the model and to develop it further (Aaltonen et al., 1997; Haarakangas, 1997; Keränen, 1992; Seikkula, 1991, 1993; Seikkula, Alakare & Aaltonen, 2000). The following were found to be most critical points in developing the new system: (1) 1984, when treatment meetings were organized in the hospital instead of systemic family therapy (see below); (2) 1987, when a crisis clinic was founded in the hospital to organize case-specific teams in cases of inpatient referral; and (3) 1990, when all the mental health outpatient clinics started to organize mobile crisis interventions teams.

Following the various research programs and psychotherapy training, seven main principles of treatment have been established.

1. *Immediate help*. The units arrange the first meeting within 24 hours of the first contact by the patient, a relative, or a referral agency. In addition to this, a 24-hour crisis service is set up. One aim of the immediate response is to prevent hospitalization in as many cases as possible. The psychotic patient participates in the very first meetings during the most intense psychotic period.

2. *A social network perspective*. The patients, their families, and other key members of their social network are always invited to the first meetings to mobilize support for the patient and the family. The other key members may be representatives of other bodies, including state employment agencies and state health insurance agencies whose task is to support vocational rehabilitation, fellow workers, the head of the patient's workplace, neighbors or friends.

3. *Flexibility and mobility*. These are guaranteed by adapting the treatment response to the specific and changing needs of each case, using the best suited therapeutic methods. The treatment meetings are, with the approval of the family, organized at the patient's home.

4. *Responsibility*. Whoever contacted the family is responsible for organizing the first meeting. Here the treatment decision is made and the team takes charge of the entire treatment.

5. *Psychological continuity*. The team takes responsibility for the treatment for as long as needed in both the outpatient and inpatient setting. The representatives of the patient's social network participate in the treatment meetings for the entire treatment sequence, including when other therapeutic methods are applied. The process of an acute psychotic crisis can be expected to last two to three years (Jackson & Birchwood, 1996). In the present study, 65 % of treatments were discontinued at the end of the second year.

6. *Tolerance of uncertainty*. This is strengthened by means of building up a sense of trust for the joint process. In psychotic crises, an adequate sense of security presupposes meeting every day at least for the first 10–12 days. After this, meetings are organized on a regular basis according the wishes of the family. Usually no detailed therapeutic contract is made in the crisis phase. Instead, at every meeting it is discussed whether and if so, when the next meeting will take place. In this way premature conclusions and treatment decisions are avoided. For instance, neuroleptic medication is not commenced in the first meeting, instead, its advisability should be discussed in at least three meetings before implementation.

7. *Dialogism*. The focus is primarily on promoting dialogue and secondarily on promoting change in the patient or in the family. Dialogue is seen as a forum through which families and patients are able to acquire more agency in their own lives by discussing the problems (Haarakangas, 1997; Holma & Aaltonen, 1997). A new understanding is built up among those participating in the discussion (Andersen, 1995; Bakhtin, 1984; Voloshinov, 1996).

The last two principles were established as hosting guidelines in 1994–1996 (Seikkula et al., 1995).

The main forum for therapeutic interaction is the treatment meeting. Here, the major participants in the problem, together with the patient, gather to discuss all the issues associated with the problem. All management plans and decisions are also made with everyone

present. According to Alanen (1997), the treatment meeting has three functions: (1) to gather information about the problem, (2) to build a treatment plan and make all decisions needed on the basis of the diagnosis made in the conversation, and (3) to generate a psychotherapeutic dialogue. On the whole, the focus is on strengthening the adult side of the patient and on normalizing the situation instead of focusing on regressive behavior (Alanen et al., 1991). The starting point for treatment is the language of the family, that is, how each family has, in their own language, named the patient's problem. The treatment team adapts its language to each case according to need. Problems are seen as a social construct reformulated in every conversation (Bakhtin, 1984; Gergen, 1994, 1999; Shotter, 1993a, 1993b; 1997). Each person present speaks in his or her own voice and, as Anderson (1997) has noted, listening becomes more important than the manner 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 the others. In the beginning, these are not challenged, but the patient is asked to say more about his or her experiences. Team members can comment on what they hear to each other as a reflective discussion while the family listens (Andersen, 1995). The therapeutic conversation resembles that described by Andersen (1995), Anderson (1997), Anderson and Goolishian (1988), Friedman (1995), Penn (1998), and Penn & Frankfurt (1994).

From the social constructionist point of view, psychosis can be seen as one way of dealing with terrifying experiences in one's life that do not have a language other than the one of hallucinations and delusions. Ogden (1990) sees psychosis as a paradoxical trial both to maintain and to destroy meaning. For example, most female psychotic patients have experienced physical or sexual abuse either as a child or as an adult (Goodman, Rosenberg, Mueser & Drake, 1997). In clinical situations, such traumatic experiences are often present in the hallucinations or delusions the patients are presenting (Karon, 1999; Karon & VandenBos, 1981). In the therapeutic conversation, it seems to be important to avoid naming the traumatic experience as the reason for psychosis. In some cases, psychosis can be caused by biological or chemical factors or by organic brain damage, but, as a psychological experience, psychosis does not have a reason. Psychotic reactions should be seen, instead, as attempts to make sense of one's experience and to cope with experiences that are so heavy that they have made it impossible to construct a rational spoken narrative. In subsequent stress situations, these experiences may be actualized, and the person speaks of them in the form of a metaphor. This is the prenarrative quality of psychotic experience (Holma & Aaltonen, 1997; Ricoeur, 1991).

One patient, for instance, became psychotic from the fear that her husband was under the influence of drugs and would come and kill her. During the second meeting, it was discovered that 16 years earlier she had been living with a man who was a heavy drug abuser. While under the influence of drugs, he had repeatedly beaten her, a fact that she had never disclosed to anyone else. A couple of months before the psychotic episode, the man had phoned her for the first time in 16 years, and she said that she became panic-stricken after hearing his voice. The fear she felt towards her husband was a psychotic one; he was not coming to kill her. At the same time, however, she was referring to something she really had experienced, that is, violence at the hands of her (former) husband.

Such experiences of victimization are not stored in that part of the memory system that promotes sense-making through the use of language. Instead they are stored in the memory of the body by the sense of terror instilled at the time. In this sense, on the basis of clinical experience, the hypothesis can be proposed that psychotic reactions greatly resemble traumatic experiences. Van der Kolk & Fisher (1995) and his team have reported how the horrors of traumatic experiences may start to live in the form of flashbacks without the individual being aware of what these brief memory fragments actually include. They may also take the form of dissociation, which very much resembles that of psychotic episodes (Penn, 1998).

Although it is not the case that every patient has been a victim of physical or sexual assault, this notion serves as guideline for dealing with psychotic experiences through dialogue in the patient´s social network. An open dialogue, without any preplanned themes or forms seems to be important in enabling the construction of a new language in which to express difficult events in one's life. These events may be of any kind, they may have happened at any time, and many types of content can open up a path for a new narrative. Whatever their background, it is important to take hallucinations seriously and not to challenge the patient´s reality during the crisis situation, especially in the beginning phase of treatment. Instead, the therapist could ask: "I do not follow how is it possible that you can control other people´s thoughts. I have not found myself able to do that. Could you tell me more about it?" The other network members in the meetings could then be asked: "What do you others think of this? How do you understand what M is saying?" The purpose of such questioning is to allow different voices to be heard concerning the themes under discussion, including the psychotic experience. If the team manages to generate a deliberating atmosphere allowing different, even contradictory, voices to be heard, the network has the possibility of constructing narratives

of restitution or reparation (Stern, Doolan, Staples, Szmukler, & Eisler, 1999). As Trimble (2000) puts it, when comparing the dialogical approach to the ideas of network therapy, "restoration of trust in soothing interpersonal emotional regulation makes it possible to allow others to affect us in dialogical relationships" (p. 15). This may be one aspect of the process where the patient and his or her social network can begin to construct new words for their problems.

Patients often start to voice psychotic stories during the meeting at some point when the most sensitive and essential themes are being discussed concerning the psychosis. Acting on the hypothesis that it is just at that point that something of the not-yet-spoken experiences are touched upon, allows that point to be brought under closer scrutiny. One can ask, for instance, "What did I say wrong, when you started to speak about that?" OR "Wait a moment, what were we discussing when M started to speak of how the voices have the control over him?" Psychotic speech can be seen as one voice among the other voices present in the actual conversation. The "reason" for psychotic behavior can be seen in the conversation at those crucial points.

In general, the role of the team in the meeting is to allow the patient´s network to take the lead in producing the content and to respond to each utterance in a dialogical way to promote building up new understanding among the different participants (Bakhtin, 1984; Voloshinov, 1996). One way to respond is to initiate reflective conversation (Andersen, 1995) among the team members. No specific reflective team is formed, but the team members move flexibly from constructing questions and comments to having reflective discussions with other team members. Sometimes this presupposes that the team asks for permission to do this: "I wonder if you could wait a moment so that we might discuss what we have started to think about. I would prefer if you could sit quietly and listen if you want or not if you do not want that. Afterwards we will ask your comments on what we have said." Usually the family and the rest of the social network listen very carefully to what the professionals in charge say about their problems. The reflective discussion has a specific task, because the treatment plans are constructed in these conversations. All is transparent. Decisions about hospitalization, whether or not to medicate, and the planning of individual psychotherapy are some examples of the content, and in each case, the goal is opening up a range of alternatives from among which a course of action is chosen. For instance, in the case of a decision to opt for compulsory treatment, it seems important that different opinions and even disagreement about the decision be openly acknowledged and discussed.

Any of the traditional methods of treatment may be used if they

are judged necessary. The patient can have individual therapy or other therapies (e.g., art therapy, group therapy, occupational therapy); the family can meet for family therapy. In psychotic crises, both psychiatric and vocational rehabilitation is focused upon from the very beginning. For instance, jointly with the state employment and national insurance agencies, special vocational rehabilitation courses, varying in length between two weeks and six months, can be organized.

Some of the ideas of systemic family therapy (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1978; 1980) are utilized in OD. In particular, positive connotation, the ideas of circular reasoning instead of linear causality, and in a few cases, some parts of circular questioning have been adopted. But there are differences, too. OD does not focus on the family system or even on communication within the family system (Boscolo & Betrando, 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 a new language, in which things can start to have different meanings, (Anderson & Goolishian, 1988, 1992; Anderson, 1997). This shift in understanding the quality of the problems is best expressed by the idea of listening to what people say, not to what they mean. In interviews and conversations in systemic family therapy, the therapist often focuses on the ways of behaving and communicating that lie behind the surface behavior.

In OD, to build up new words and a new language, the focus is on the words that are said. This resembles the ideas of many social constructionist writers (Gergen, 1994; Shotter, 1993a, 1993b). Among family therapists working with social constructionist ideas, however, the treatment of psychotic patients has not received much attention. Michael White (1995) has described narrative therapy with psychotic patients, and Holma and Aaltonen (1997) 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 they are different in how they view the author of the narrative. Whereas the narrative therapist aims at reauthoring the problem-saturated story, in dialogic approaches, the aim is to move from monologues which are stuck to more deliberative dialogues (Smith, 1997). In narrative therapy the narrative has an author, in dialogical therapies a new narrative is cocreated in the shared domain of the participants. Gergen and McNamee (2000) appropriately termed OD a "transformative dialogue."

OD and psychoeducational programs (Anderson, Hogarty & Reiss, 1980; Falloon, 1996; Falloon, Boyd, McGill, 1984; Goldstein, 1996; McGorry, Edwards, Mihalopoulos, Harrigan, & Jackson, 1996) share the view that the family is an active agent in the process. The family is 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 differences lie in the theoretical assumptions about psychosis, OD emphasizing meetings during the most intensive crisis situation and the process quality of constructing treatment plans. On the basis of the stress-vulnerability model (Zubin & Spring, 1977), in psychoeducational models the aim is generally to form a diagnosis and choose a treatment program that corresponds to the diagnosis, although this does not always succeed (McGorry et al., 1996). The diagnosis is the basis for educating the family to improve its communication in order to prevent relapses and enhance remission (Falloon et al., 1984; Gleeson, et al., 1999; McFarlane, Link, Dushay, Matchal, & Crilly, 1995a and McFarlane et al., 1995b).

As seen above, OD belongs to the wide variety of constuctivist approaches, emphasizing the social nature of our constructions. As Neimeyer and Raskin (2001) note, constructivist ideas in psychotherapy share the aim of building a nonpathologizing discourse around the patient´s problem, respect for personal narratives and definitions of the problem, and the context of treatment as an elementary aspect of the problem. It is not a question of denying "the real world," as some have claimed (Held, 1995), but of emphasizing the importance of how the therapists themselves, by organizing the treatment response, become coconstructors of the problem. To subscribe to the notion of relativity, for which the social constructionist has been criticized (Cromby & Nightingale, 1999), is not to deny the existence of a physical environment, but to highlight that there is no any absolute form of psychosis or schizophrenia, for example. Psychotherapy is liberated from the quest to judge a client´s personal reality by extraspective criteria of objectivity (Neimeyer & Raskin, 2001). Objectivity in a clinical context means aiming at defining permanent problems in the form of a diagnosis. Disordering discourse, which relates to a different type of diagnostic manual, leads to the stigmatization of patients and to treatment in which the goal becomes one of treating an illness. This leads, only too easily, to disempowerment of the individual, seeing the illness, not the person, as the main agent in his or her treatment (Gergen & McNamee, 2000). In this type of structural language, illness is seen the same way regardless of context, as if it were the same from patient to patient.

OD includes social constructionist ideas and focuses on generating dialogue because dialogue is seen as something that is con-structed in the area between interlocutors (Bakhtin, 1984; Voloshinov, 1996). Psychological reality is, in all cases, constructed by using language in a special way. If we opt for the disordering discourse type of diagnosis, we treat the symptoms of an illness, but if, instead, we aim at generating polyphonic dialogues within the social network, we

become interested in everyone's voice regarding the problem. We no longer think of a specific illness as the agent but of the language in which the meaning-making process takes place. We enter into a "transformative dialogue" (Gergen & McNamee, 2000). This seems to be a common feature of many constructivist therapies, which emphasize personal narratives instead of general truths.

Turning the focus on dialogism is a new element in psychotherapy, but it has its origins in ancient Greeks history. Plato, for one, saw the self as a social construction (Nightingale, 2000). In his early texts, Socrates, in particular, was described as one who helps interlocutors to create the truth in an ongoing dialogue; it was not his task to find the answers (Bakhtin, 1984). The power of dialogism had already been seen. The blossoming period of ancient Greek sciences (philosophy, medicine) and arts (poetry, sculpture) took place in the same classical era when assemblies of citizens took the ideal form of dialogues. At that time, they had not been corrupted, and there was no special class of people, rhetoricians, who had started to make use of such meetings for their own ends, but they were instead open and creative forums for all free citizens (Volkov, 1974). Perhaps the idea of open treatment meetings includes a return to some of the democratic ideals of the ancient Greeks.

Case Illustration

The following case is presented to illustrate the process of OD. Treatment usually starts with the team being given a small amount of information about the case. In the present case, Siiri´s mother called the local mental health outpatient clinic on a Monday morning to ask for help for her daughter, who had started to speak of her extreme terror that a gang was going to force its way into her apartment. The nurse who answered the phone thought Siiri might be having psychotic problems, and suggested a meeting straightaway, on the afternoon of the same day. Siiri´s mother did not want a home visit, but preferred to meet at the clinic. The nurse contacted the psychiatrist of the clinic and the crisis clinic of the psychiatric hospital and thus a three-person team was invited to participate in the treatment. Surprisingly, Siiri´s mother did not turn up at the first meeting. The following sequence consists of the very first comments made at the meeting. S stands for Siiri, N1 and N2 for the nurses.

N1: Where should we start?
S: The whole. . . . I can't really remember anything.

N2: Has it been that you don't really remember anything for a long time?

S: Well . . . I don't know if it has been that way since midsummer. I do remember if I've been in contact with someone and all the things that have happened. But then that I've left my own place, I don't know if I was even there, but suddenly came into being and find myself wherever it is and so...

N2: Whom are you living with?

S: I'd been living by myself, but now I've gone to my parents.

. . .

N1: Whose idea was it that you came here?

S: Well . . . my mother's.

N2: And what was your mother worried about?

S: I don't know if I've spoken about it with her. I really can't remember anything. I have a feeling that I may even have hit someone, but I just can't remember.

N2: Has anyone said this to you?

S: No. . . . I am paranoid and so you think that something has happened.

N2: What about father? Is he worried about any particular matter?

S: I don't know, but yesterday evening when we were watching TV he went to bed, and in the morning he had gone to work.

N2: And what was it like then?

S: I was afraid, I was quarrelling with that guy. They have a key to my place and they . . . they were asshole fucking in July and did all these kinds of things.

N2: In July?

The discussion began with Siiri´s comment and the team continued her theme, with the team members adapting their questions to Siiri´s utterances. Instead of adopting a specific interviewing method, such as circular questioning, the team strove to capture Siiri´s experience in her own terms. It is important to start every discussion with the client's words in order to have the client's experience as the basis for the dialogue.

Siiri's story became more and more violent and, simultaneously, the structure of the sentences dissolved, which can be seen as a sign of her overwhelming fear and confusion. In the beginning, the team asked very concrete questions about her life, and the story was coherent and comprehensible. Dialogue was possible between Siiri and the team, but this situation radically changed after she remembered her father being absent that morning. The story became more and more threatening and psychotic, and the team's confusion grew in the course of the discussion. One way out might have been for the team to use internal reflective discussion, but Siiri´s way of describing her terrible experiences

seemed to inhibit this. Although the team did not recognize it, it might be suggested that Siiri´s experience of her father and his absence was important in Siiri´s crisis.

At the end of the first meeting, it was agreed that the next meeting would take place the following day at Siiri's home. In this meeting her parents and her brother were present.

(At the outset, Siiri´s parents described several incidents and Siiri's condition)

N2: What does it mean that Siiri's condition got better and got worse?

Father: I think it's almost certain a month ago...

Mother: It was the 16th.

F: Siiri was in her own place where she was living, but during that phase the situation developed that it was necessary to go after her. She spent a few days here at home. It could be seen, of course, that Siiri was restless, and she just kept walking around, and then there were the very powerful terrors, assaults, and all kinds of persecution and such things that she talked about. I didn't know what was real and what was imagined, but she started to relax and she stayed here at home. Then she said that she wanted to go back to her own place where she stayed for one day and went back into the same state and started talking. Last week we had the problem that we had my dad's funeral, and there was a lot of work to do and organizing but Siiri was still here.

. . .

N2: Do you have some idea about the assaults she spoke of?

M: Once her face was black and blue, she had been fighting or something . . . it was a month ago (*laughing*).

N2: It was this summer?

M: And she also had a swollen hand.

F: That gang that Siiri has been a member of this last year or two, I've said that Siiri should get away from it and its bad influence on her.

The discussion was continued fluently as if it were a continuation of the first interview. Siiri's mother and father both had plenty of opportunity to tell their stories about Siiri's problem. They spoke in language which was quite difficult to follow, in a nonpersonal way. They sounded as if they were presenting a report without any personal emotions, although they talked of their ideas that Siiri had probably been assaulted or abused. The team did not take these things as symptoms, but remained curious about the assaults.

The treatment process started with very closely spaced meetings.

Siiri calmed down in the beginning, to the extent that she stopped speaking about her fears, but at the same time, she also discontinued going out from her parent's home and gradually began to keep herself apart from her friends and others. Family problems rapidly began to emerge. Her father had left the family, as they stated, "for Siiri´s sake." Gradually, the family began to talk about the father's drinking problem, which did not, however, come into the open so that discussion about it was possible. After six months of treatment the process became bogged down, so that referring Siiri to the hospital was seen as the only alternative. After a one-week period in hospital a treatment meeting was organized where the family, the treatment team, and the ward team were present. At the end of the meeting a discussion began within the team about the difficult situation regarding both the family and the treatment.

N2: What do you, Lisa (*the mother*), think about this?

M: Well. . . . (*Siiri stands up.*)

F: You're the one who has quite a lot to say in this matter, who are living here . . . (*gives a deep sigh*).

M: It's like everyday life, I think she will manage by herself there (*at home*), but she hasn't made any progress (*laughing*).

Psych1: Matti (*the father*) has quite clearly given his own thoughts but Siiri´s mother's opinion is still rather unclear (*turns to the ward psychologist; Siiri sits down*).

N1: That's her opinion that no progress has been made.

Psych2: Lisa has said that Siiri could come home but no progress has been made.

M: Will there ever be any progress where nothing else can happen?

S: If now I am in a state that no more progress can happen.

M: Yeah. . . .

Ps2: Paavo (*the team´s psychologist*), you think that Matti clearly expressed his point of view?

Ps1: Well, Matti clearly said that the situation can't continue where she only stays in bed, since this makes Lisa angry.

Ps2: But, on the other hand, Matti is saying why don't we take Siiri home. He says it both ways, yes and no, and, I think, Siiri´s mother also says yes and no..

Ps1: But, I think, Matti is looking for some solution that could happen if Siiri comes back home in order to guarantee her mother some rest. Siiri could be in her own place, as well.

N2: It might be good for Lisa's rest but would it be good for Siiri?

M: What is better for Siiri, is it at home or here?

S: Home.

Ps2: Now there is a third alternative; She could be home either with Lisa or with Matti and then there is also this ward.

Previously there were only two places, now it is more complicated.

Ps1: And then if one thinks, at the beginning we promised to take responsibility because this situation can't continue.

N2: It was our decision.

Ps2: What could they, Matti and Lisa, have been thinking when you made the decision?

S: I for one am leaving now (leaves the room).

Ps1: I don't know.

Ps2: If I imagine that it were my child and someone else is taking charge of her . . .

M: It was a relief.

F: I guessed already a long time ago that this would happen. . . . I think she's now much more alert than before; now she's giving her opinions. It's progress; she doesn't just lay around any more.

Ps2: Would it be possible to continue tomorrow, since this is becoming more and more hazy all the time. . . ?

After a long meeting it was agreed to have a new meeting the next day. The discussion was now dialogical with joint understanding being constructed together. When someone said something, he or she formulated the utterance so that a response to it was necessary; without it the dialogue could not proceed. This is the definition of the dialogical utterance (Bakhtin, 1984). However, the interaction within the family was so difficult that, even within this dialogue, permanent solutions to the problem could not be found. It was not possible to bring the conflicts into the open by discussion. The only alternative was for the father to leave home.

Siiri went home but very soon returned to the hospital because her fears and stories had become even more intense. For instance, she described how Manfred Vörner´s agents were haunting her. She also said that two nuclear warheads were aimed at the hospital from northern Norway and most of the people outside the hospital had been killed.

On the ward there was a lot of discussion with Siiri about her fears. However, the discussions did not calm her. Instead, they stimulated her even more, so that one day she assaulted a doctor in the ward corridor. She said that this doctor was a Russian agent who wanted to kill her. Actually, he was the same doctor who had participated in the first treatment meeting, but not in subsequent meetings. During the two-and-one-half month period that she stayed in the hospital, she began to calm down a little, but she still spoke a lot about her fears. Neuroleptic medication was also started but this did not have any rapid effect on her fears. She continued talking about powerful external threats. The family discussions were continued, and her

father began to talk about his drinking problem, and he became very depressed and began to talk about suicide. He was hospitalized for a couple of nights. After this episode, the family's situation began to improve so that the parents decided to buy a larger residence in order to move back together and to have Siiri at home. After this Siiri was discharged from the hospital and, in this phase, the first noticeable improvement towards a more secure reality occurred. She began rapidly to calm down and to visit her friends. During the following months, she every now and then talked about her fears and visited the hospital for a two-week period after a severe quarrel with her parents and younger brother.

Two years after the outset of treatment, Siiri was living at home with her family without expressing any obvious psychotic ideas, and the family discussions continued on a once-a-month basis. She had had individual psychotherapy for one year, but now she wanted to discontinue it. She had a boy friend and they planned to become engaged. In the five-year follow-up interview, Siiri had not had any psychotic symptoms for the previous three years, although her treatment had continued in the form of psychological and vocational rehabilitation. She had taken a couple of vocational rehabilitation courses organized by the state employment agency. The treatment meetings, which involved the family and Siiri, were organized with the idea of supporting Siiri and her family in building their new life.

DISCUSSION

Several of the seven treatment principles of OD can be illustrated by this example. Treatment was started immediately, with the first meeting being called within six hours after the initial contact made by the mother. The nurse who was contacted took the responsibility for organizing the first meeting, and those who participated were the main members of the team for the entire course of the treatment. This is one element in psychological continuity. A second element in psychological continuity was the fact that the team working with the family in their home participated actively in the meeting held in the ward as well. Perhaps one problem to do with responsibility and psychological continuity in this case was the fact that the doctor who participated in the very first meeting was not present at subsequent meetings. This was not discussed in the meetings, and it might have raised questions in Siiri's mind. The treatment plans were adapted to the specific and varying needs of the family. In the crisis phase, daily meetings were organized at their home, hospitalizationwas decided upon when needed,

neuroleptic medication was started after her temporary progress gave way to relapse, individual psychotherapy was organized and, during the final phase of her treatment, the focus was on rehabilitation activities. The team tolerated uncertainty. This was seen in the content of the dialogue, where efforts were made to understand the problems of the whole family in the context of their lives as they were living them instead of "disordering discourse." It was also seen in the way that the team stood up to the difficult situation during the first six months of treatment, when Siiri´s condition improved but the conflict between her mother and father became more and more evident.

The main problems in following the principles of OD were perhaps in fulfilling the social network perspective and dialogism. With hindsight, it can be argued that there should, perhaps, have been meetings with the network with which Siiri had encountered violent problems. During the treatment process, it became evident that Siiri did in fact have serious problems with the gang, which also led to her summons to court in connection with drug abuse and committing thefts. The problems experienced in generating dialogue were probably related to the conflicts within the family, especially between the mother and father, which led to their separation for a two-year period. The team, although it tolerated the uncertainty, did not manage to initiate deliberating dialogue before Siiri and her father were hospitalized. Reflective, open discussion became possible only after a treatment process lasting half a year. It was important to take into account all the issues within the family, not only Siiri´s problems.

CONCLUSION

In this article, we have outlined the main principles and practices that characterize Open Dialogue, our approach to the treatment of serious psychological disturbances in keeping with a social constructionist perspective. Hallmarks of this approach include the establishment of a consistent treatment team that participates in respectful, deliberative dialogue with the patient and family from the point of first referral, with an emphasis on daily meetings during the period of initial crisis. Unlike approaches that attempt to orchestrate treatment around a formal diagnosis, OD views the dialogic opening up of possibilities as itself curative, and the transparency of all treatment decisions in the presence of patient and family accords with this principle. Likewise, even the psychotic responses of the patient are regarded as potentially meaningful and important to consider, as they often refer metaphorically or indirectly to "real" problems in the patient's life. Our experience with

this process, even in difficult cases like that of Siiri and her family, has encouraged us to adopt it as a model of service provision over a large area of Finland, where it has helped humanize treatment for hundreds of patients contending with psychotic problems. We hope that this report, and the accompanying article in this issue, outlining the impact of the OD model, will encourage others involved in the treatment of serious problems to consider innovative procedures that draw upon social constructionist and constructivist concepts.

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