

Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies

JAAKKO SEIKKULA¹, JUKKA AALTONEN¹, BIRGITTU ALAKARE²,
KAUKO HAARAKANGAS³, JYRKI KERÄNEN⁴, & KLAUS LEHTINEN⁴

¹University of Jyväskylä, ²University of Oulu, ³Western Lapland Health District, ⁴Western Lapland Health District, and
⁵Tampere University Hospital

(Received 18 January 2004; revised 10 June 2004; accepted 12 July 2004)

Abstract

The open dialogue (OD) family and network approach aims at treating psychotic patients in their homes. The treatment involves the patient's social network and starts within 24 hr after contact. Responsibility for the entire treatment process rests with the same team in both inpatient and outpatient settings. The general aim is to generate dialogue with the family to construct words for the experiences that occur when psychotic symptoms exist. In the Finnish Western Lapland a historical comparison of 5-year follow-ups of two groups of first-episode nonaffective psychotic patients were compared, one before (API group; $n = 33$) and the other during (ODAP group; $n = 42$) the fully developed phase of using OD approach in all cases. In the ODAP group, the mean duration of untreated psychosis had declined to 3.3 months ($p = .069$). The ODAP group had both fewer hospital days and fewer family meetings ($p < .001$). Nonetheless, no significant differences emerged in the 5-year treatment outcomes. In the ODAP group, 82% did not have any residual psychotic symptoms, 86% had returned to their studies or a full-time job, and 14% were on disability allowance. Seventeen percent had relapsed during the first 2 years and 19% during the next 3 years. Twenty nine percent had used neuroleptic medication in some phase of the treatment. Two cases from both periods are presented to illustrate the approach.

In the context of the Turku project and Finnish National Schizophrenia Project (Alanen, 1997; Salokangas, Rääköläinen, & Stengård, 1991), Alanen et al. 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. Treatment was seen as a continuous process involving the integration of different therapeutic methods and constant monitoring of progress and outcomes (Alanen, 1997; Alanen, Lehtinen, Rääköläinen, & Aaltonen, 1991). On the basis of these programs, 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 the provision of psychotherapeutic treatment for all patients within their own personal support systems. This is done by generating dialogues within the treatment system and families and involves mobile crisis intervention teams, patients,

and their social networks in joint meetings. In what follows, the OD and the study carried out to determine its effectiveness are described.

The province of Western Lapland (72,000 inhabitants during the study periods) 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 in religion, the population is homogenous. More than 90% are Finnish-speaking Lutheran Finns. Ninety percent of the population lives within 60 km of Keropudas Psychiatric Hospital. The incidence of schizophrenia has been extremely high: In the mid-1980s, for example, there was an annual average of 35 new schizophrenia patients per 100,000 inhabitants (Aaltonen et al., 1997).

All five mental health outpatient clinics and the Keropudas Psychiatric Hospital with its 30 acute-care beds set up case-specific mobile crisis intervention teams. In principle, all clinical staff members can be called on to participate in these teams

according to specific needs. Therefore, most of the inpatient and outpatient staff, totaling about 100 professionals, participated in 3-year training in family therapy or in psychodynamic individual psychotherapy from 1989 through 1998. The family therapy training was conducted as on-the-job training in cooperation with the University of Jyväskylä. Qualification as a psychotherapist by Finnish legal standards was obtained by 75% of the staff.

In a crisis, regardless of the diagnosis the same procedure is followed in all cases. If it is a question of a referral to hospital treatment, 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 compulsory patients). In the first meeting, the team has the authority to decide not to hospitalize the patient. 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 regardless of whether the patient is at home or in the hospital and irrespective of how long the treatment is expected to last. In crises in which 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. For instance, in cases of clients who are involved with several agencies at the same time, 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 same ideas have been extended to cover the clinical practice of the entire state social and health care system in the province, not only the psychiatric system.

The most critical steps in developing the new system were taken (a) in 1984, when treatment meetings began to be organized in the hospital, replacing systemic family therapy (see later discussion); (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 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 that have been undertaken (Aaltonen et al., 1997; Haarakangas, 1997; Keränen, 1992; Seikkula, 1991, 1994).

1. The provision of immediate help. The clinics arrange the first meeting within 24 hr of the first contact, made either by the patient, a relative, or a referral agency (since 1987). In addition to

this, a 24-hr crisis service exists (since 1992). The aim of immediate meeting is to integrate the outpatient treatment as soon as possible with the patient's everyday life and, in that case, even to prevent hospitalization in many cases. 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 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 include official agencies, such as the local employment and health insurance agencies, to support vocational rehabilitation, fellow workers, or the employer, 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 suit each case. The meetings are often 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 multiprofessional family meeting, in which decisions about continuation and site of treatment are made. The team then takes charge of the entire treatment process (since 1993, 1994).
5. Psychological continuity. The role of the team is not only to take care of the treatment as such but also to guarantee both the creation of new psychological meanings for symptoms and shared experience of this process (Aaltonen & Rökköläinen, 1994). The team is responsible for the treatment for as long as it takes in both outpatient and inpatient settings. Members of the patient's social network are invited to participate in the meetings throughout the treatment process. The various methods of treatment are combined so as to form an integrated process (since 1988).
6. Tolerance of uncertainty. Building a relationship in which all parties can feel safe enough in the joint process strengthens this. According to our experience, 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. By so doing, both the tolerance of uncertainty and a possibility for some certainty increase. After this the meetings are organized regularly according to a joint plan. Usually no detailed therapeutic contract

is made in the crisis phase. Instead, all parties discuss as a routine part of every meeting whether and when the next meeting will take place. Meetings are conducted so as to avoid premature conclusions or decisions about treatment. For instance, neuroleptic medication is not introduced in the first meeting; instead, its advisability is 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. In dialogue patients and families increase their sense of agency in their own lives by discussing the patient's difficulties and problems (Haarakan-gas, 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). Instead of having some specific interviewing procedure, 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 during 1994 to 1996 (Seikkula et al., 1995).

Mihail Bakhtin and Valentin Voloshinov created the idea of dialogism for describing a specific type of communication and interaction, in which the participants in dialogue become cocreators of the shared reality. As far as the authors of this study are aware, in family therapy their ideas were transformed into psychotherapeutic dialogue by the OP team. For a more profound description of the importance of dialogism in understanding the OD approach, we recommend that reader become familiar with those texts (Seikkula 1993, 1995; Seikkula et al., 1995; Seikkula & Olson, 2003). In individual psychotherapy, for instance, Leiman and Stiles (2001) have used Bakhtinian dialogism to develop specific methods for analyzing the psychotherapeutic process. In individual psychotherapy, however, many authors have referred to dialogue already before their work. For instance, the ideas of Jacques Lacan have been said to resemble a lot of Bakhtin's description of dialogism.

In the meetings all management plans and decisions are also made with everyone present. According to Alanen (1997), the meeting has three functions: (a) to gather information about the problem, (b) to plan treatment and on the basis of the diagnosis and evaluation made in the course of the conversation make all decisions needed, and (c) to generate a psychotherapeutic dialogue. Problems are seen as social constructions, emerging in

conversation among people (Bakhtin, 1984; Berger & Luckmann, 1966; Gergen, 1994; Gergen, 1999; Shotter, 1993). Each person has his or her own voices in constructing the problem, and listening to others (patient, family, and the treatment team) becomes more important than any specific way of interviewing (H. Anderson, 1997). 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, these are not challenged, but the patient is encouraged to tell more about personal experiences.

As a summary of the approach, OD integrates different methods of treatment so as to form a single treatment process. The patient can have, during the treatment process, different kinds of therapies (e.g., family, psychodynamic individual, group, occupational, pharmacological) according to the changing needs, which emerge in the meetings with the case-specific team. In cases of psychotic crisis, vocational rehabilitation is focused on from the beginning.

Certain ideas from systemic family therapy (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978; Cecchin, & Prata, 1980), especially of circular reasoning rather than linear causality, positive connotation, and some aspects of circular questioning, 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, 1993, 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 H. Anderson (1997) have described it. In OD, therapists do not focus on ways of behaving and communicating that are behind manifest behavior, as is done in the systemic family therapy.

Compared with narrative therapies, both OD and narrative therapies share the social constructionist view of reality but differ in their understanding of the authorship of new narratives. In OD, the therapist focuses on the words that are said in order to build up new words and a new language. This is in line with the ideas of social constructionist writers (Berger & Luckmann, 1966; Gergen, 1994; Gergen & McNamee, 2000; Shotter, 1993). 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. 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 cocreated in the space between the participants.

OD and psychoeducational programs (C. 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 the crisis situation and the process quality of building treatment plans. Psychoeducational approaches most often aim at determining an exact diagnosis and choosing the treatment program according to that diagnosis (McGorry, 1999) to prevent relapses and 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, Link, Dushay, Matchal, & Crilly, 1995; McFarlane, Lukens, et al., 1995; Mueser, Wallace, & Liberman, 1995; Perris & McGorry, 1998).

Evaluation of effectiveness in treatment of first-episode psychosis

There are not many 5-year follow-up studies on first-episode psychosis. In a treatment-as-usual setting, Svedberg, Mesterton, and Cullberg (2001) reported a 5-year outcome of first-episode psychotic patients treated in Stockholm from 1991 to 1992 before the development of a psychosocial program in the area. Of the patients 54% were diagnosed as schizophrenia at the outset (M age = 30 years). During the 5-year period, the mean length of hospitalization was 110 days, and neuroleptic medication was used in 93% of cases. As an outcome, 62% of the patients were living on a disability allowance at the 5-year follow-up.

Generally, 40% of schizophrenia patients are considered to have improved after follow-ups averaging 5.6 years (Hogarty et al., 1997); average rate of a favorable outcome declines over time to 36%.

For specific psychosocial programs, most studies of outcome have dealt with family psychoeducational, 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, 1999; Falloon, 1996; Garbone, Harrigan, McGorry,

Curry, & Elkins, 1999; Larsen, Johannesen, & Oppjordsmoen, 1998; Yung et al., 1998).

The most frequently used 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). In recent psychosocial programs, Lieberman (1996) found that 86% of schizophrenic 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 years of treatment have varied between 14% and 35% (Lieberman, 1996; Linszen, Lenior, de Haan, Dingemans, & Gersons, 1998; McGorry et al., 1996); however, risk of relapse increases if the treatment was shifted to another treatment place (Linszen, Dingeman, & Lenior, 2001; Linszen, Dingemans, Scholte, Lenior, & Goldstein, 1998). After 5 years, 74% relapsed or were in treatment throughout the period, and more than 50% were on a disability allowance (Lenior, Dingemans, Linszen, de Haan, & Schene, 2001). Family psychoeducation and social skills training became less effective against late relapse in the second year after discharge (Hogarty et al., 1997). More than 50% of patients were found to be living on disability allowance after 2 and 5 years (Gupta, Andreasen, Arndt, & Flaum, 1997; Shepherd, 1998; Svedberg et al., 2001).

Surprisingly, in the studies of need-adapted treatment by K. Lehtinen (1993) and Cullberg, Thoren, Åbb, Mesterton, 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; K. Lehtinen, 1993). If the use of neuroleptics was postponed in the beginning of treatment process, they were later seen as necessary only in about 50% of all psychotic patients (Cullberg et al., 2000; V. Lehtinen, Aaltonen, Koffert, Rökköläinen, & Syvälahti, 2000). It is noted elsewhere that employment status was better when placebo was used instead of neuroleptic medication, if the duration of untreated psychosis was shorter than 1 year (Johnstone, Macmillan, Frith, Benn, & Crow, 1990)

Study design

The effectiveness of OD was explored in the context of the Finnish national multicenter Integrated Treatment of Acute Psychosis (API) project, which ran from April 1, 1992, through December 31, 1993, with a follow-up of 2 and 5 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 (V. Lehtinen et al., 1996, 2000). Western Lapland was one of the six research centers. All first-episode cases of nonaffective psychosis (based on *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., rev. [DSM-III-R]; American Psychiatric Association, 1987) were included. After December 31, 1993, it was decided to continue the project on the local level in Western Lapland. The continuation period, named the Open Dialogue Approach in Acute Psychosis (ODAP), ran from January 1, 1994, through March 31, 1997, and it forms the study group, which is historically compared with its earlier phase API group in the same area. A report of a 2-year follow-up of schizophrenia patients with a comparison to treatment as usual has been given elsewhere (Seikkula et al., 2003).

The aim of the API project was to analyze how the principles of the need-adapted approach can be applied in different treatment cultures. One of the specific aims was to study whether the starting of neuroleptic medication can be postponed or avoided, or the doses decreased, if the principles are intensively applied in all cases. Three research centers, of which Western Lapland was one, sought to avoid starting the use of neuroleptic medication during the early stage of treatment. The results of these three centers were compared with three others in which the use of medication was decided to be as usual in their treatment. In Western Lapland, as in the other two centers, 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 progress in the psychotic symptoms or in the social behavior of the patient, neuroleptic medication was considered. The aim was to find ways to integrate the medication as a part of a psychosocial treatment as any other treatment methods that are used according to a specified need. In this report, only results of a historical comparison in Western Lapland are given. The results of a 2-year follow-up of the comparison between all of the research centers are given elsewhere (V. Lehtinen et al., 2000).

This study was not planned as a randomized trial to evaluate a treatment method but rather was a descriptive study of the entire treatment system in a single catchment area. The local ethical committee gave permission for the study, and every patient gave written informed consent to inclusion. This report describes the results for the two different groups of psychotic patients in Western Lapland (API and ODAP groups). The system of treatment had already been reorganized during the API period, but it was not until the ODAP period, since 1994, that it

became possible to integrate it as a part of the treatment of all first-episode patients. The staff then 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 in treatments are not categorical but, in the ODAP period treatment, were 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 API period can be seen as an earlier phase in the development of ODAP period.

Samples

At the 2-year follow-up, complete data were available for 34 API patients and 46 ODAP patients and at the 5-year follow-up for 33 API and 42 ODAP patients. One patient during the API period and one during the ODAP period (both diagnosed with brief psychotic episode) were excluded because of their treatment starting based on other principles. One API patient (schizophreniform psychosis) and two ODAP patients (schizophreniform psychosis and schizophrenia) refused to participate. Two API patients (brief psychotic episode) and three ODAP patients (two brief psychotic episodes, one schizophreniform psychosis) were not reached at the follow-ups. None of them had any known psychiatric treatment contact in the province. The API patients had moved to another part of the country for jobs, as did two of the ODAP patients. No information was reached for one ODAP patient. Disregarding these dropouts, the material stands for all psychotic patients in Western Lapland during both periods (Table I).

Table I. Reasons for exclusion from the study in the api and odap groups during the 5-year follow-up period.

| Variable | API | ODAP |
|--------------------------------------|-----|------|
| Treatment started | 39 | 51 |
| Treatment started in unit outside OD | 1 | 1 |
| Refused to participate | 1 | 2 |
| Not reached at 2 year follow-up | 2 | 2 |
| Not reached at 5 year follow-up | 0 | 1 |
| Deceased | 2 | 3 |
| Total sample ^a | 33 | 42 |

Note. API: April 1, 1992–December 31, 1993; ODAP: January 1, 1994–December 31, 1997. API = Integrated Treatment of Acute Psychosis project; ODAP = Open Dialogue Approach in Acute Psychosis project.

^aAt 5-year follow-up.

The analysis was done by (a) conducting a historical comparison between the API and ODAP groups to see whether the results from the API period persisted and whether further changes or improvements were forthcoming when the approach was applied in all cases (most staff members had a specialist level training in psychotherapy) and (b) analyzing two cases of both periods to illustrate the treatment processes in different phases of the development of OD. The evaluations were done both at the baseline and 2 and 5 years thereafter. No significant differences appeared in age, sex, marital, or employment status or in diagnosis; hence, the groups can be regarded as comparable with each other (Table II).

The diagnosis was made in two phases. After the first meeting, the team, jointly with the responsible chief psychiatrist (author BA), formulated an initial hypothesis, and after 6 months, having also interviewed the patients individually, the chief psychiatrist made the final diagnosis. To test reliability, an experienced psychiatrist from outside the region re-diagnosed the patients by reading the patient records. The level of diagnostic consistency of the schizophrenia diagnosis was 78% ($\kappa = .453$, $p = .002$).

Method

The main sources of information were (a) premorbid variables such as psychological and employment

status at the outset and duration of untreated psychosis (DUP; defined as the time between first psychotic symptoms and the start of psychosocial intervention); (b) process variables (i.e., registered number of hospital days, number of family meetings, and registration of the use of neuroleptic medication and individual psychotherapy), and (c) outcome variables (i.e., registered number of relapses [defined as making a new contact for treatment after terminating the original treatment or an intensification of existing treatment because of new psychotic or other symptoms], employment status, and ratings of the mental state of patients using the Brief Psychiatric Rating Scale [BPRS], Global Assessment of Function Scale, and a 5-point rating of the Strauss-Carpenter Rating Scale [0 = no symptoms; 1 = mild symptoms almost all the time or moderate occasionally; 2 = moderate symptoms for some time; 3 = prominent symptoms for some time or moderate symptoms all the time; 4 = continuous prominent symptoms; Strauss & Carpenter, 1972; Opjordsmoen, 1991]). The ratings were jointly done, using a consensus conference method, by JS and BA, who, as researchers, were not involved as therapists in the specific treatment process. All the just-mentioned ratings were done at baseline and at 2- and 5-year follow-ups. During the first treatment meetings, the family was interviewed about the duration of psychotic and prodromal symptoms before the first contact. BA verified this during her confidential interview with the patient. The follow-up interviews were conducted in the

Table II. Characteristics and premorbid adjustment at the baseline of the patients reached in the follow-up in the two groups.

| Variable | API ($n = 34$) | ODAP ($n = 46$) | Statistic | p |
|----------------------------------|------------------|-------------------|---------------------|-----------|
| Age (years) | | | $F(2, 57) = .019$ | <i>ns</i> |
| Range | 19–38 | 17–43 | | |
| M | 26.6 | 26.8 | | |
| Sex | | | $\chi^2(2) = 0.765$ | <i>ns</i> |
| Male | 16 (47%) | 16 (35%) | | |
| Female | 18 (53%) | 30 (65%) | $\chi^2(1) = 1.228$ | <i>ns</i> |
| Marital status | | | $\chi^2(6) = 4.166$ | <i>ns</i> |
| Single | 20 (59%) | 34 (74%) | | |
| Married/living together/divorced | 14 (41%) | 12 (26%) | $\chi^2(3) = 4.589$ | <i>ns</i> |
| Employment status | | | $\chi^2(3) = 3.067$ | <i>ns</i> |
| Studying | 11 (32%) | 13 (28%) | | |
| Working | 14 (41%) | 24 (52%) | | |
| Unemployed | 3 (9%) | 6 (13%) | | |
| Passive | 6 (18%) | 3 (7%) | | |
| Diagnosis/DSM-III-R | | | $\chi^2(3) = 2.767$ | <i>ns</i> |
| Brief reactive psychosis | 5 (15%) | 11 (24%) | | |
| Unspecified psychosis | 7 (21%) | 10 (22%) | | |
| Schizophreniform psychosis | 9 (26%) | 6 (13%) | | |
| Schizophrenia | 13 (38%) | 19 (41%) | | |

Note. Unemployed = to have been working during the last 2 years but at the moment unemployed and registered as job seeking at the employment services. Passive = being without searching for a job; API = Integrated Treatment of Acute Psychosis project; ODAP = Open Dialogue Approach in Acute Psychosis project; DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.).

presence of both the case-specific treatment team and the family. At this interview the main theme was the realization of the seven OD principles (immediate help, social network perspective, flexibility, responsibility, psychological continuity, tolerance of uncertainty, and dialogism). First, the patient and the family were interviewed, after which the team commented on what the family had said and reported their own experiences, and, in the final phase, the family members gave their comments on what they felt was important. After the follow-up interview, BA and JS scored the realization of each main principle on a scale ranging from 0 to 3 (0 = realized adequately; 1 = realized in the main but with small exceptions; 2 = partially realized; 3 = not realized). BA and JS first made their own suggestions, and then a consensus was negotiated.

The statistical analysis was conducted using the Pearson chi-square in cross-tables, and a one-way analysis of variance (ANOVA) for the comparison of the means of independent groups.

Results

Comparison of the groups at follow-up

Treatment processes. The DUP was 3.3 months during the ODAP period compared with 4.2 months in the API period ($p = .069$), as shown in Table III. In both periods the median of DUP was 2 months, so the difference in the mean DUP was due to fewer patients with long DUP in ODAP group. The treatment was discontinued without a joint decision in 18% of the API and 5% of the ODAP group patients. The ODAP group had fewer hospital days during the first 2 years ($p < .001$), but at the 5-year follow-up no difference emerged. Up to the 5-year follow-up, ODAP patients had fewer family treatment meetings (Table III; $p < .001$). Neuroleptic medication was used to about the same extent in both groups at both follow-ups (Table IV). In both groups, at the 5-year follow-up, more patients were on ongoing neuroleptic medication, which might suggest that in a new crisis neuroleptics were used more readily than in the first episode of the crisis. Of the ODAP patients reached at the 5-year follow-up, 17% were using neuroleptics compared with 24% of API patients (Table IV). Altogether, during the entire 5-year period, 39% of API patients and 29% of ODAP patients used neuroleptic medication.

Treatment outcomes. At least one relapse occurred in 27% of API and 17% in ODAP cases during the first 2 years and in 32% of API and 19% of ODAP cases between Years 2 to 5 (Table V). During the

entire 5-year period, 29% of ODAP group patients had at least one relapse versus 39% of API patients. These differences were not statistically significant. Concerning symptoms, the API group patients seemed to recover slower, because at the 2-year follow-up a difference in BPRS occurred (Table III; $p < .001$). Also in the rating of psychotic symptoms, API patients tended to have poorer ratings at the 2-year follow-up ($p = .069$; Table III). At the 5-year follow-up, these differences no longer occurred. At that point, 82% of ODAP patients had no residual psychotic symptoms compared with 76% of API patients. In employment status, no differences emerged. Seventy percent of the API and 76% of the ODAP patients reached at the 5-year follow-up had returned to their work or studies; 27% of API patients and 14% of ODAP patients were living on a disability allowance (Table V).

Case illustrations

In the following two cases, the treatment processes are illustrated and possible differences during the two phases highlighted. The cases have been chosen to illustrate two examples of a severe psychotic crisis. The criteria for selection of the cases were as follows: (a) schizophrenia or schizophreniform psychosis diagnosis; (b) treatment discontinued by agreement before the 2-year follow-up; (c) no neuroleptic medication use; (d) successful recovery from a severe psychosis (a rating of psychotic symptoms of 3 or more at the outset and 0 at the 5-year follow-up); (e) returned to studies or job or registered as job seeking by the employment authorities. Altogether, seven API patients and 10 ODAP patients matched all these criteria. The cases presented next were selected because their families gave illustrative information of the treatment processes, and they also pointed to problems that were not seen looking at the mere ratings or other statistical information.

Patient 1(API): "From isolation to motherhood."
Diagnosis: schizophreniform psychosis. Simone, a 22-year-old student, had entered the local primary care center over the weekend after taking an overdose of sleeping pills. The following Monday morning the general practitioner called a psychologist at the local psychiatric outpatient clinic, and the psychologist mobilized a team composed of a psychiatrist and a psychologist from the crisis clinic at the hospital and one nurse from the outpatient clinic. The team went to the patient's home the same afternoon, 6 hr after the contact was made at the crisis clinic.

At home, Simone and her three sisters, mother, and father were present. They said that they had started to become worried about Simone during the

Table III. Means of treatment process and outcome variables in the two groups at baseline and at the 2- and 5-years follow-ups.

| Variable | API (<i>n</i> = 33) | ODAP (<i>n</i> = 42) | <i>t</i> | <i>p</i> |
|-------------------------------|----------------------|-----------------------|----------|-----------|
| DUP (months) | | | 3.40 | .069 |
| <i>M</i> | 4.3 | 3.3 | | |
| <i>SD</i> | 7.0 | 3.8 | | |
| Range | 0–25 | 0–13 | | |
| Hospitalization days | | | | |
| 2-year follow-up | | | 11.51 | <.001 |
| <i>M</i> | 25.7 | 9.3 | | |
| <i>SD</i> | 44.2 | 18.3 | | |
| Range | 0–52 | 0–50 | | |
| 5-year follow-up | | | 2.38 | <i>ns</i> |
| <i>M</i> | 16.7 | 7.4 | | |
| <i>SD</i> | 40.4 | 35.5 | | |
| Range | 0–182 | 0–224 | | |
| No. family treatment meetings | | | | |
| 2-year follow-up | | | 0.99 | <i>ns</i> |
| <i>M</i> | 26.1 | 20.7 | | |
| <i>SD</i> | 14.1 | 20.6 | | |
| Range | 2–55 | 0–99 | | |
| 5-year follow-up | | | 16.32 | <.001 |
| <i>M</i> | 10.6 | 3.8 | | |
| <i>SD</i> | 16.3 | 7.9 | | |
| Range | 0–62 | 0–25 | | |
| BPRS | | | | |
| Baseline | | | 3.27 | <i>ns</i> |
| <i>M</i> | 47.2 | 46.4 | | |
| <i>SD</i> | 12.8 | 9.4 | | |
| 2-year follow-up | | | 23.17 | <.001 |
| <i>M</i> | 30.2 | 23.7 | | |
| <i>SD</i> | 12.9 | 4.5 | | |
| 5-year follow-up | | | 2.90 | <i>ns</i> |
| <i>M</i> | 23.1 | 24.6 | | |
| <i>SD</i> | 5.4 | 8.8 | | |
| Residual psychotic symptoms | | | | |
| Baseline | | | .25 | <i>ns</i> |
| <i>M</i> | 3.21 | 2.98 | | |
| <i>SD</i> | .64 | .80 | | |
| 2-year follow-up | | | 3.53 | .064 |
| <i>M</i> | .50 | .30 | | |
| <i>SD</i> | .90 | .70 | | |
| 5-year follow-up | | | .02 | <i>ns</i> |
| <i>M</i> | .39 | .35 | | |
| <i>SD</i> | .79 | .86 | | |

Note. Five-year follow-up consists of information of events between 2 and 5 years after the baseline. API = Integrated Treatment of Acute Psychosis project; ODAP = Open Dialogue Approach in Acute Psychosis project; BPRS = Brief Psychiatric Rating Scale (a 19-items instrument rated on a scale ranging from 1–9); DUP = duration of untreated psychosis.

last 5 months after she had returned home from her studies at university. She stayed home instead of visiting her friends. Earlier she had had an active social network to such an extent that her parents had been worried about possible drug abuse and liberal sexual behavior. They had tried to speak with Simone. However, Simone had not acknowledged any problems and started to speak of religious thoughts instead.

In the meeting, both the parents and one of the sisters were very active in their descriptions of Simone. Simone was silent most of the time, and

when she talked, she talked about how she had seen Jesus and other persons from the Bible walking on the streets. In the meetings, it was decided not to admit Simone to the hospital but rather to organize home treatment. The next home visit, it was decided, would be held the following day. In this meeting she was more active and described her hallucinations and psychotic thoughts. An intense treatment process started, involving nine family meetings during the following 2 months. In these meetings, mostly the mother and one of the sisters were present. During the end of the process, Simone

Table IV. Frequencies in treatment process variables in the two groups at 2- and 5-year follow-ups.

| Variable | API | ODAP | $\chi^2(df)$ | <i>p</i> |
|-------------------------------|----------|----------|--------------|-----------|
| Use of neuroleptics | | | | |
| 2-year follow-up ^a | | | | |
| Started | 9 (26%) | 12 (26%) | 0.400(2) | <i>ns</i> |
| Ongoing | 5 (15%) | 5 (11%) | | |
| 5-year follow-up ^b | | | | |
| Started | 10 (30%) | 8 (19%) | 1.460(2) | <i>ns</i> |
| Ongoing | 8 (24%) | 7 (17%) | | |
| Individual psychotherapy | | | | |
| 2-year follow-up ^a | | | | |
| Yes | 12 (33%) | 21 (46%) | 1.420(2) | <i>ns</i> |
| No | 22 (67%) | 25 (54%) | | |
| 5-year follow-up ^b | | | | |
| Yes | 14 (42%) | 14 (33%) | 0.653(1) | <i>ns</i> |
| No | 19 (58%) | 28 (67%) | | |

Note. Five-year follow-up consists of information between 2 and 5 years after the baseline. API=Integrated Treatment of Acute Psychosis project; ODAP=Open Dialogue Approach in Acute Psychosis project.

^aAPI, *n* = 34; ODAP, *n* = 46. ^bAPI, *n* = 33; ODAP, *n* = 42.

became extremely agitated and angry with her father when she remembered how he had tried to get her to participate in swimming sports during her childhood about 10 years before. Her father had not been satisfied with her practice and had criticized her strongly. In the last family treatment meetings, the team proposed discontinuing the meetings, and Simone started to have individual psychotherapy with a psychologist at the outpatient clinic. After 9 months a crisis occurred between her and her parents. Because she did not have any other place to move to, she was hospitalized for 46 days. After

Table V. Frequencies of outcome variables in the two groups at 2-year follow-up.

| Variable | API | ODAP | $\chi^2(df)$ | <i>p</i> |
|-------------------------------|----------|----------|--------------|-----------|
| No. relapse cases | | | | |
| 2-year follow-up | | | | |
| 5-year follow-up | 9 (27%) | 8 (17%) | 2.23 (3) | <i>ns</i> |
| 5-year follow-up | 11 (32%) | 8 (19%) | 3.11 (2) | <i>ns</i> |
| Employment status | | | | |
| 2-year follow-up ^a | | | | |
| Studying or working | 21 (62%) | 35 (78%) | 7.29(4) | <i>ns</i> |
| Unemployed | 4 (12%) | 6 (13%) | | |
| Disability allowance | 9 (26%) | 4 (9%) | | |
| 5-year follow-up ^b | | | | |
| Studying or working | 23 (70%) | 32 (76%) | 2.96 (3) | <i>ns</i> |
| Unemployed | 1 (3%) | 4 (10%) | | |
| Disability allowance | 10 (27%) | 6 (14%) | | |

Note. Unemployed = to have been working but at the moment unemployed for more than 2 years and registered as job seeking at the employment services. API=Integrated Treatment of Acute Psychosis project; ODAP=Open Dialogue Approach in Acute Psychosis project.

^aAPI, *n* = 34; ODAP, *n* = 46. ^bAPI, *n* = 33; ODAP, *n* = 42.

the inpatient period she went back home. She no longer had any psychotic symptoms, but she started to become depressed; therefore, the individual psychotherapy continued for an additional year. Twenty family treatment meetings were held in total.

At the 2-year follow-up, Simone was living at home with her parents and they had a joint souvenirs business. She had no positive symptoms but was rather silent and had almost no contact with her friends. At the 5-year follow-up, only her mother was met. She described how Simone had stayed at home for a total of 4 years and how the parents became worried about her. However, that summer Simone had suddenly packed her belongings onto a bicycle and took a ride to France, actually 2,000 km. She spent 1.5 months on her trip, and after returning home her mother said that they saw how she had changed. At that point, 1 year before the follow-up interview, she had met a man with whom she had fallen in love, they had bought a house, and she was pregnant with her first baby.

When asked about their experiences of the treatment, all of the family had been satisfied with arranging the home visits instead of hospitalization. Although they had wanted the neuroleptic medication, after Simone refused to take it, the parents had accepted it. Her father sent his greetings to the 5-year follow-up meeting. He said that he had not liked the discussions because they opened old wounds in the family. Simone had said to her mother that it is best for her to avoid too many visits home because of the threat of quarrels with her father.

In analyzing this case, the seven main principles of OD had been mostly realized. The treatment started immediately with those people nearest to the patient present. The same team was responsible throughout the process, and together with the family they tolerated the uncertainty in the process, especially during the phase in which Simone presented her strong emotions toward her father. The greatest problems seemed to occur in dialogism, because the family, especially the father, had felt that the dialogue opened up old wounds. It was not possible to handle the difficult family relations, but, on the other hand, the family found a way to proceed and to have their relations in a new form.

Patient 2 (ODAP): "Taking care of his studies."
Diagnosis: schizophrenia. Martti was 16 years when, during his first year in the vocational school, he started to show signs of problems to his parents. He became easily irritated and isolated himself in his room during weekends at home. He continued to go to a school in another city, where he also lived in a flat. The following April everything seemed to fall apart. He stopped taking care of his hygiene, his

talking went to a mumble, and his eyes were turned toward the sky. He also had peculiar body movements, such as rocking. His parents were unable to have any contact with him and took him into primary care. At that point of time, his psychotic symptoms had continued for 1 month. He 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 him at the primary care center together with his parents. It was decided that Martti would return home, and home visits were arranged. Meetings were held every day or every second day. During the first meetings Martti most often sat with his knees under his jaw and his eyes turned toward the sky. When asked a question, he did not answer. Only some mumbling was heard. His parents were very worried, and they both cried a lot; his sister returned home to support them. In many meetings, neuroleptic medication was considered, but the parents did not like that idea, and the psychiatrist wanted to be careful. In these meetings, a slight progress was noted in the sense that Martti started to sleep better, and he also started to give short answers to the team members.

During the summer, after 3 months treatment, a 5-week break occurred in the meetings at the request of the family. New meetings were agreed on consensually, and after 6 months from the outset, surprising to everyone, Martti said that he was going to return to his studies. Both the parents and the team members were very suspicious. They did not believe that Martti could cope with his studies and living away from home. After discussing this at two meetings, the team approved Martti's initiative but proposed network meetings at Martti's school. In two meetings, Martti, with his family, the principal of the school, Martti's closest teacher, and the school nurse, discussed the support needed by Martti. Although the team proposed continuing the family treatment meetings, the family disapproved, saying that after Martti 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. Martti was no longer psychotic, and he was going to take his exam from the vocational school. His parents said that they were worried all the time, although nothing alarming had happened. When asked of their experiences, they were satisfied that Martti had not been hospitalized, although in the beginning it was a rather difficult situation for them to bear. They were also satisfied with not having used neuroleptic medication. Martti used anxiolytic medication for 3 months to help him sleep in the beginning. In the process they had not liked some

circular questions (as they are used in the systemic family therapy¹) asked by one member of the team, which the mother had felt increased her guilt about Martti's psychosis.

At the 5-year follow-up, the entire family was seen, and Martti said that he had taken a second occupation after he did not find any job for his first occupation. He had not had any psychotic symptoms, although every now and then he felt anxiety. He had started to think that he will probably start individual psychotherapy to clarify to himself what had happened during his crisis. His parents said that their life has become much more serious than before. His mother even said that "laughter has disappeared from our life." They said that it would have been good to have some family meetings, for instance, once a year to meet with the team and to tell of their life.

In analyzing this case, the main principles of OD had mostly been applied. Perhaps the sadness of the family afterward describe some problems in the principle of dialogism in the sense that, although the family did not initially want further family treatment meetings, the team did not generate dialogue, in which other voices of the situation had been heard, as well. Only after 5 years were the other family member's unmet needs being heard. Nonetheless, in comparison to the previous case, the idea of mobilizing the social network was more applied and that seemed to give more positive results.

Discussion

The aim of this study was to analyze the results of the treatment gained during the API phase to see whether they were sustained or improved during the ODAP period. No significant differences occurred in the outcomes at the 5-year follow-up. Instead, the patients seem to recover faster from their psychosis during the ODAP period, because the API group had more symptoms at the 2-year follow-up. Differences occurred in the treatment processes: hospital treatment had decreased in the ODAP group during the first 2 years, and fewer family treatment meetings were organized in the ODAP group between 2 and 5 years. The duration of untreated psychosis had a tendency of declining during the ODAP period, when it was 3.3 months ($p = .069$). On the other hand, no results were poorer in the ODAP group, which gives reason to conclude that the same outcomes were reached by less treatment efforts.

The limitations of the data and study design should be noted. Psychosis is a rare problem, and in small samples even a single patient being moved between categories may affect statistical significance. In a historical comparison, many variables, which

were not controlled for, may have affected the outcome. The criteria for including patients in the treatment may change, and staff members may change and bring with them personal variables that are not controlled for. The researchers performing the ratings were involved in developing the OD approach, which raises the risk of bias for more positive ratings of the ODAP period. To minimize this kind of bias, more objective data on the use of treatment and the registration of employment status were included, and the ratings of psychological status and symptoms should be seen as supporting this information.

In spite of these limitations of the design, the results support some reasonable inferences about need-adapted approach and one of its modifications, OD, compared with treatment as usual. In the Svedberg et al. (2001) Stockholm 5-year follow-up, 54% of patients were diagnosed with schizophrenia, which was about the same as in the ODAP group. In Stockholm, the mean age seemed to be higher (30 years vs. 27 years in ODAP group). This might indicate either that in Stockholm the age of having psychotic problems was higher or that the DUP was longer. Compared with the current study, DUP has been reported to be much longer in a treatment-as-usual setting compared with either API or ODAP, having an average between 1 to 3 years (Kalla et al., 2002; Larsen et al., 1998). The mean length of hospitalization was 110 days with the Stockholm patients compared with 17 days with the ODAP patients. Neuroleptic medication was used in 93% of cases in the Stockholm group compared with 29% in the ODAP group. As an outcome, 62% of the patients treated in Stockholm were living on a disability allowance compared with 14% in the ODAP group. In the Linzsen et al. (2001) study, after an effective psychosocial program, the patients were referred to other treatment agencies and the good results did not persist. Only 25% managed without at least one relapse, and their social function level was poor. In the current study, most of these problems were avoided. Of ODAP patients, 29% had a relapse during the 5-year period and 86% had returned to an active social life in the sense that they were working, studying, or actively job seeking.

These results should be compared with caution because the groups were not matched with each other. In the Netherlands study, more patients had a schizophrenia diagnosis (93%) compared with the ODAP group (54%). Thus, the group was poorer already in the beginning of the treatment. However, in a 2-year follow-up of schizophrenia patients in the ODAP group, no more than 23% were living on a disability allowance, and thus the same results were obtained comparing only the schizophrenia patients

(Seikkula et al., 2003). The differences may be seen as illustrating how the network-oriented treatment with immediate response in a crisis may enhance the treatment of first-episode psychotic patients. Hospitalization can be decreased, and the outcomes seem to improve in the sense that fewer patients were living on a disability allowance.

The main difference between the need-adapted OD approach and other contemporary psychosocial programs is that, although most of them focus on increasing the coping skills of the patient and the family, in OD, in addition to this, a concrete cooperation is taking place by mobilizing the relevant parties in the patient's future, such as employers, fellow employees, and state employment agencies for as long a time as seems adequate. This was well illustrated in the second case, in which network meetings were organized at the occupational school. One other possible factor in the good social outcome compared with treatment as usual (Svedberg et al., 2001) and time-limited psychosocial projects (Lenior et al., 2001) could be, as Lenior et al. (2001) noted, the avoidance of neuroleptic medication in most of the cases. Johnstone et al. (1990) reported better occupational outcome if placebo instead of neuroleptic was used.

The case analysis gave additional information about the treatment processes. For the API case, DUP was 6 months, and for the ODAP case, 1 month. Even during the API phase, the treatment was organized immediately, and an intense process started. The team tolerated the uncertainty of both psychotic symptoms and difficult internal family relations. The main difference was that the API group patient was hospitalized for 46 days. The second difference seemed to be the active mobilization of the social network in the ODAP case to support the patient to return to his studies.

The cases provided important specific problems, which were not seen in the statistical analysis. In the first case, although the patient recovered from the symptoms and returned to an active social life, family relationships became impossible to handle and during the process old wounds were opened without having the possibility to develop more constructive interaction in the family. The only possibility that was left for the patient was to decrease family contact to protect her. The outcome perhaps was not that adequate, because the process took a long time, which might have affected her life both during this period and afterward. In the second case, the intense process during the most serious psychotic phase seemed to be effective, because the patient returned to his studies regardless of his psychotic symptoms and recovered afterward. At follow-up, it was seen that the psychotic process had

affected both the patient and the entire family to the extent that the family's way of living changed. This gives reason to suggest that the treatment of psychosis within a family is a much broader experience in life than just recovering from the symptoms. The family had learned something, and they could make use of their tight connections with each other, but at the same time their ability to enjoy life was decreased, and this had not been handled in the treatment process. In neither case was neuroleptic medication. A question for the future research remains: whether a low dose of medication would have helped to gain the outcomes more rapidly and thus prevented a quite long time of isolation, as happened in the first case.

OD, as developed in Western Lapland, is not an expensive approach; rather, it is a cost-effective one for the community. Building up a new system has meant moving hospital staff to crisis intervention work in the outpatient setting. Although no analysis of the cost-effectiveness of OD has been conducted, it is nonetheless possible to make a comparison on the financing of state health care in Finland because of the deep recession of 1991, which led to drastic nationwide cuts in the resources available to psychiatry. The costs of the psychiatric health district in Western Lapland decreased by 33% from the end of the 1980s through to the mid-1990s, and they were the lowest among the health districts in Finland. Although professionals view these cuts in funding as unfair and threatening, especially in the treatment of long-term patients, the decrease has not affected the quality of the treatment of first-episode psychotic crises, as can be seen in this study. There is, however, a study in another catchment area in Finland that shows that organizing a multiprofessional psychosis team is significantly more cost-effective compared with a hospital-centered treatment (Saari, 2002). Compared with many time-limited projects, the advantage of the Western Lapland model is that the OD approach has been built 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.

Note

¹ Circular questioning is a specific way of interviewing the family first introduced by the Milan systemic group (Selvini-Palazzoli et al., 1980). In the questions, differences are highlighted by, for example, asking one family member to evaluate a relation of two others after the crisis occurred. Another form of asking of differences is to ask to rate who is most concerned, who is the second most concerned, and who is third most concerned.

References

- Aaltonen, J., & Rääkköläinen, V. (1994). The shared image guiding the treatment process. A precondition for integration of the treatment of schizophrenia. *British Journal of Psychiatry*, *164*(Suppl. 23), 97–102.
- Aaltonen, J., Seikkula, J., Alakare, B., Haarakangas, K., Keränen, J., & Sutela, M. (1997). Western Lapland project: A comprehensive family- and network centered community psychiatric project. In *ISPS. Abstracts and lectures 12–16 October 1997* (p.124). London: ISPS.
- Alanen, Y. (1997). *Schizophrenia. Its origins and need-adapted-treatment*. London: Karnac Books.
- Alanen, Y., Lehtinen, K., Rääkköläinen, V., & Aaltonen, J. (1991). Need-adapted treatment of new schizophrenic patients: Experiences and results of the Turku Project. *Acta Psychiatrica Scandinavica*, *83*, 363–372.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.
- Andersen, T. (1995). Reflecting processes. Acts of informing and forming. In S. Friedman (Ed.), *The reflective team in action* (pp. 11–37). New York: Guilford Press.
- Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving: ideas about the implications for clinical theory. *Family Process*, *27*, 371–393.
- Anderson, C., Hogarty, G., & Reiss, D. (1980). Family treatment of adult schizophrenic patients: Psycho-educational approach. *Schizophrenia Bulletin*, *6*, 490–505.
- Anderson, H. (1997). *Conversation, language, and possibilities*. New York: Basic Books.
- Bakhtin, M. (1984). *Problems of Dostoevskij's poetics: Theory and History of Literature, Volume 8*. Manchester, UK: Manchester University Press.
- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality*. New York: Doubleday/Anchor.
- Boscolo, L., & Bertrando, P. (1993). *The times of time*. New York: Norton.
- Bustillo, J., Lauriello, J., Horan, W., & Keith, S. (2001). The psychosocial treatment of schizophrenia: An update. *American Journal of Psychiatry*, *158*, 163–175.
- Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. Chichester, UK: Wiley.
- Cullberg, J., Thoren, G., Åbb, S., Mesterton, A., & Svedberg, B. (2000). Integrating intensive psychosocial and low dose neuroleptic treatment: A three-year follow-up. In B. Martindale, A. Bateman, M. Crowe & F. Margison (Eds), *Psychosis: Psychological approaches and their effectiveness* (pp. 200–209). London: Gaskell Press.
- Eckman, T., Wirsching, W., Marder, S., Liberman, R., Johnston-Cronk, K., Zimmerman, K., & Mintz, J. (1992). Technique for training schizophrenic patients in illness self-management: a controlled trial. *American Journal of Psychiatry*, *149*, 1549–1555.
- Edwards, J., & McGorry, P. (1998). Early intervention in psychotic disorders: A critical step in the prevention of psychological morbidity. In C. Perris & P. McGorry (Eds), *Cognitive psychotherapy of psychotic and personality disorders* (pp. 167–196). Chichester, UK: Wiley.
- Fadden, G. (1998). Research update: Psychoeducational family intervention. *Journal of Family Therapy*, *20*, 293–309.
- Falloon, I. (1996). Early detection and intervention for initial episodes of schizophrenia. *Schizophrenia Bulletin*, *22*, 271–283.
- Falloon, J., Boyd, J., & McGill, C. (1984). *Family care of schizophrenia*. New York: Guilford Press.
- Garbone, S., Harrigan, S., McGorry, P., Curry, C., & Elkins, K. (1999). Duration of untreated psychosis and 12-month

- outcome in first-episode psychosis: The impact of treatment approach. *Acta Psychiatrica Scandinavica*, 100, 96–104.
- Gergen, K. (1994). *Realities and relationships. Soundings in social construction*. Cambridge, MA: Harvard University Press.
- Gergen, K. (1999). *An invitation to social construction*. London: Sage.
- Gergen, K., & McNamee, S. (2000). From disordering discourse to transformative dialogue. In R. Neimeyer & J. Raskin (Eds), *Construction of disorders* (pp. 333–349). Washington, DC: American Psychological Association.
- Gleeson, J., Jackson, H., Stavely, H., & Burnett, P. (1999). Family intervention in early psychosis. In P. McGorry & H. Jackson (Eds), *The recognition and management of early psychosis* (pp. 376–406). Cambridge, UK: Cambridge University Press.
- Gupta, S., Andreasen, N., Arndt, S., & Flaum, M. (1997). The Iowa longitudinal study of recent onset schizophrenia: One-year follow-up of first episode patients. *Schizophrenia Research*, 23, 1–13.
- Haarakangas, K. (1997). Hoitokokouksen äänet. The voices in treatment meeting. A dialogical analysis of the treatment meeting conversations in family-centred psychiatric treatment process in regard to the team activity. English summary. *Jyväskylä Studies in Education, Psychology and Social Research*, 130, 119–126.
- Hogarty, G., Kornblith, S., Greenwald, D., DiBarry, A., Cooley, S., Ulrich, R., et al. (1997). Three-year trials of personal therapy among schizophrenic patients living with or independent of family: I. Description of study and effects on relapse rates. *American Journal of Psychiatry*, 154, 1504–1513.
- Holma, J., & Aaltonen, J. (1997). The sense of agency and the search for a narrative in acute psychosis. *Contemporary Family Therapy*, 19, 463–477.
- Jackson, C., & Birchwood, M. (1996). Early intervention in psychosis: Opportunities for secondary prevention. *British Journal of Clinical Psychology*, 35, 487–502.
- Johnstone, E., Macmillan, F., Frith, C., Benn, D., & Crow, T. (1990). Further investigation of the predictor of outcome following first schizophrenic episode. *British Journal of Psychiatry*, 187, 182–189.
- Kalla, O., Aaltonen, J., Wahlstroem, J., Lehtinen, V., Cabeza, I. G., & Gonzalez de Chaevez, M. (2002). Duration of untreated psychosis and its correlates in first-episode psychosis in Finland and Spain. *Acta Psychiatrica Scandinavica*, 106, 265–275.
- Keefer, J., & Koridar, E. (1994). Essential elements of a family psychoeducation program in the aftercare of schizophrenia. *Journal of Marital and Family Therapy*, 20, 369–380.
- Keränen, J. (1992). The choice between outpatient and inpatient treatment in a family centred psychiatric treatment system. English summary. *Jyväskylä Studies in Education, Psychology and Social Research*, 93, 124–129.
- Larsen, T., Johannesson, J., & Opjordsmoen, S. (1998). First-episode schizophrenia with long duration of untreated psychosis. *British Journal of Psychiatry*, 172(Suppl. 32), 45–52.
- Lehtinen, K. (1993). Need-adapted treatment of schizophrenia: A five-year follow-up study from the Turku project. *Acta Psychiatrica Scandinavica*, 87, 96–101.
- Lehtinen, V., Aaltonen, J., Koffert, T., Rääköläinen, V., & Syvälahti, E. (2000). Two year outcome in first-episode psychosis treated according to an integrated model. Is immediate neuroleptisation always needed? *European Psychiatry*, 15, 312–320.
- Lehtinen, V., Aaltonen, J., Koffert, T., Rääköläinen, V., Syvälahti, E., & Vuorio, K. (1996). Integrated treatment model for first-contact patients with a schizophrenia-type psychosis: The Finnish API project. *Nordic Journal of Psychiatry*, 50, 281–287.
- Leiman, M., & Stiles, W. (2001). Dialogical sequence analysis and the zone of proximal development and conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research*, 11, 311–330.
- Lenior, M., Dingemans, P., Linszen, D., de Haan, L., & Schene, A. (2001). Social functioning and the course of early-onset schizophrenia: Five-year follow-up of a psychosocial intervention. *The British Journal of Psychiatry*, 179, 53–58.
- Lieberman, R., & Corrigan, W. (1993). Designing new psychosocial treatments for schizophrenia. *Psychiatry*, 56, 237–249.
- Lieberman, R., & Green, M. (1992). Whither cognitive-behavioral therapy. *Schizophrenia Bulletin*, 18, 27–35.
- Lieberman, J. (1996). Pharmacotherapy for patients with first episode, acute, and refractory schizophrenia. *Psychiatric Annals*, 26, 515–518.
- Linszen, D., Dingemans, P., & Lenior, M. (2001). Early intervention and a five year follow up in young adults with a short duration of untreated psychosis: ethical implications. *Schizophrenia Research*, 51, 55–61.
- Linszen, D., Dingemans, P., Scholte, W., Lenior, M., & Goldstein, M. (1998). Early recognition, intensive intervention and other protective and risk factors for psychotic relapse in patients with first psychotic episodes in schizophrenia. *International Clinical Psychopharmacology*, 13(Suppl 1), S7–S12.
- Linszen, D., Lenior, M., de Haan, L., Dingemans, P., & Gersons, B. (1998). Early intervention, untreated psychosis and the course of early schizophrenia. *British Journal of Psychiatry*, 172(Suppl.33), 84–89.
- Loebel, A., Lieberman, J., Alvir, J., Mayerhoffer, D., Geisler, S., & Szymanski, S. (1992). Duration of psychosis and outcome in first-episode schizophrenia. *American Journal of Psychiatry*, 149, 1183–1188.
- McFarlane, W., Link, B., Dushay, R., Matchal, J., & Crilly, J. (1995). Psychoeducational multiple family groups: Four-year relapse outcome in schizophrenia. *Family Process*, 34, 127–144.
- McFarlane, W., Lukens, E., Link, B., Dushay, R., Matchal, J., & Crilly, J. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry*, 52, 679–687.
- McGorry, P. (1999). “A stitch in time”: The scope for preventive strategies in early psychosis. In P. McGorry & H. Jackson (Eds), *The recognition and management of early psychosis* (pp. 3–23). Cambridge, UK: Cambridge University Press.
- McGorry, P., Edwards, J., Mihalopoulos, C., Harrigan, S., & Jackson, H. (1996). EPPIC: An evolving system of early detection and optimal management. *Schizophrenia Bulletin*, 22, 305–325.
- Mueser, K., Wallace, C., & Lieberman, R. (1995). New developments in social skills training. *Behaviour Change*, 12, 31–40.
- Opjordsmoen, S. (1991). Long-term clinical outcome of schizophrenia with special reference to gender difference. *Acta Psychiatrica Scandinavica*, 83, 307–313.
- Penn, D., & Mueser, K. (1996). Research update on the psychosocial treatment of schizophrenia. *American Journal of Psychiatry*, 153, 607–617.
- Perris, C., & McGorry, P. (Eds.). (1998). *Cognitive psychotherapy of psychotic and personality disorders*. Chichester, UK: Wiley.
- Saari, M. (2002). Psychosis team in treatment of severe mental disorders in Kainuu in 1992–1996. *Acta Universitatis Ouluensis. D 665*. Oulu, Finland: Medica.
- Salokangas, R., Rääköläinen, V., & Stengård, E. (1991). Uusien skitsofreniapotilaiden hoito ja ennuste V: Viiden vuoden seuranta [Treatment and prognosis of new schizophrenia patients V: 5-years follow-up. English summary]. *Reports of Psychiatrica Fennica*, 96.
- Seikkula, J. (1991). Family-hospital boundary system in the social network. English summary. *Jyväskylä Studies in Education, Psychology and Social Research*, 80, 227–232.

- Seikkula, J. (1993). The aim of therapy is generating dialogue: Bakhtin and Vygotsky in family session. *Human Systems Journal*, 4, 33–48.
- Seikkula, J. (1994). When the boundary opens: Family and hospital in co-evolution. *Journal of Family Therapy*, 16, 401–414.
- Seikkula, J. (1995). From monologue to dialogue in consultation with larger systems. *Human Systems Journal*, 6, 21–42.
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Sutela, M. (1995). Treating psychosis by means of open dialogue. In S. Friedman (Ed.), *The reflective team in action* (pp. 62–80). New York: Guilford Press.
- Seikkula, J., Alakare, B., Aaltonen, J., Holma, J., Rasinkangas, A., & Lehtinen, V. (2003). Open dialogue approach: Treatment principles and preliminary results of a two-year follow-up on first episode schizophrenia. *Ethical Human Sciences and Services*, 5, 163–182.
- Seikkula, J., & Olson, M. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Process*, 42, 403–418.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox*. New York: Jason Aronson.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing, circularity and neutrality. Three guidelines for the conductor of the session. *Family Process*, 19, 3–12.
- Shepherd, G. (1998). Development in psychosocial rehabilitation for early psychosis. *International Clinical Psychopharmacology*, 3 (Suppl 1), S53–S57.
- Shotter, J. (1993). *Conversational realities. Constructing life through language*. London: Sage.
- Smith, C. (1997). Introduction. Comparing traditional therapies with narrative approaches. In C. Smith & D. Nylund (Eds), *Narrative therapies with children and adolescents* (pp. 1–52). New York: Guilford Press.
- Strauss, J., & Carpenter, W. (1972). The prediction of outcome in schizophrenia. *Archives of General Psychiatry*, 27, 739–746.
- Svedberg, B., Mesterton, A., & Cullberg, J. (2001). First-episode non-affective psychosis in a total urban population: A 5-year follow-up. *Social Psychiatry*, 36, 332–337.
- Voloshinov, V. (1996). *Marxism and the philosophy of language*. Cambridge, MA: Harvard University Press.
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, Australia: Dulwich Center Publications.
- Yung, A., Phillips, L., McGorry, P., Hallgren, M., McFarlane, C., Jackson, H., et al. (1998). Can we predict the onset of first-episode psychosis in a high-risk group. *International Clinical Psychopharmacology*, 13 (Suppl 1), 523–530.

Zusammenfassung

Fünf Jahre Erfahrung mit der Offenen-Dialog Methode bei der Behandlung von Ersterkrankungen nicht-affektiver Psychosen: Behandlungsprinzipien, katamnestische Ergebnisse und zwei Fallstudien

Der offene Dialog (OD) eines Familien- und Netzwerkzuges zielt auf die Behandlung psychotischer Patienten zuhause ab. Die Behandlung, die das soziale Netzwerk der Patienten einschließt, beginnt innerhalb von 24 Stunden nach dem ersten Kontakt. Die Verantwortung für den gesamten Behandlungsprozess bleibt bei demselben Team, unabhängig davon, ob auch eine poliklinische oder stationäre

Behandlung eingesetzt wird. Das allgemeine Ziel besteht darin, einen Dialog mit der Familie zu beginnen und Worte für die Erfahrung zu finden, die mit der psychotischen Symptomatik verbunden ist. Für den finnischen Teil des West-Lapplands wird ein historischer Vergleich einer fünf Jahresuntersuchung von 2 Gruppen von Patienten mit dem erstmaligen Auftreten nichtaffektiver Psychosen berichtet, von einer Gruppe mit voll entwickelter Symptomatik (ODAP; n = 42), bei der in allen Fällen OD eingesetzt wurde, und einer Gruppe vor dieser Phase (API; n = 33) ohne OD. In der ODAP Gruppe wurden die psychotischen Phasen im Mittel auf 3,3 Monate verkürzt (p = .69). Diese Gruppe hatte weniger Aufenthaltstage in der Klinik und weniger Familientreffen (p = .001). Es gab aber keinen Unterschied im Therapieergebnis in dem 5-Jahreszeitraum. In der ODAP Gruppe hatten 82% der Patienten keine psychotischen Residualsymptome, 86% haben ihre Arbeit oder ihr Studium wieder aufgenommen, 14 Prozent bekamen aufgrund der vorliegenden Behinderung Sozialhilfe, 17% hatten in den ersten zwei Jahren einen Rückfall und 19% in den drei darauf folgenden Jahren. 29% wurden in einer der Behandlungsphasen mit Neuroleptika behandelt. Um die Anwendungsweise von OD zu veranschaulichen, werden zwei Fälle dargestellt.

Résumé

Cinq ans d'expérience dans l'approche du dialogue ouvert de premiers épisodes de psychose non-affective: principes de traitement, résultats de suivis, et deux études de cas

L'approche familiale et de réseau du dialogue ouvert (DO) vise à traiter les patients psychotiques dans leurs institutions. Le traitement comprend le réseau social du patient et commence dans les 24 heures après le contact. La responsabilité de tout le processus de traitement incombe à la même équipe que se soit dans un cadre hospitalier ou ambulatoire. Le but général est de générer un dialogue avec la famille pour construire en mots l'expérience vécue lorsque des symptômes psychotiques se manifestent. Dans l'ouest de la Laponie finlandaise, 5 années de suivi de deux groupes de patients avec un premier épisode de psychose non-affective ont été comparés, un avant (groupe API, n = 33) et l'autre durant (groupe ODAP ; n = 42) la phase d'utilisation complètement développée de l'OD pour tous les cas. Dans le groupe ODAP, la durée moyenne de la psychose non traitée a décliné de 3.3 mois (p = .069). Le groupe ODAP avait moins de jours d'hospitalisation et moins de rencontres familiales (p < .001). Cependant, aucune différence n'a émergé dans les résultats du traitement à 5 ans. Dans le groupe ODAP, 82% avaient encore des symptômes psychotiques résiduels, 86% avaient repris leurs études ou leur travail à plein temps, et 14% touchaient une allocation d'invalidité. 17% ont connu une rechute au cours des 2 années suivantes et 19% durant les trois années suivantes. 29% ont utilisé une médication neuroleptique à l'une ou l'autre phase du traitement. Deux cas de chaque période sont présentés comme illustration de l'approche.

Resumen

Experiencia de cinco años con un primer episodio de una psicosis no afectiva según el enfoque del diálogo abierto: principios de tratamiento, resultados del seguimiento y dos estudios de caso

El enfoque del diálogo abierto con la familia y la red social se propone tratar a los pacientes psicóticos en sus casas. El tratamiento implica a la red social del paciente y comienza dentro de las 24 horas del primer contacto. La responsabilidad de todo el proceso recae en el mismo equipo que actúa en los contextos de internación y externación. El objetivo general es la generación del diálogo con la familia para nominar las experiencias que ocurren en los casos de síntomas psicóticos. En el Finnish Western Lapland se compararon seguimientos de cinco años de dos grupos de pacientes que atravesaban por un primer episodio de psicosis no afectiva, uno antes (grupo API; $n=33$) y el otro durante (grupo ODAP; $n=42$) la fase totalmente desarrollada según el enfoque OD en todos los casos. En el grupo ODAP, la duración media de la psicosis no tratada declinó a 3.3 meses ($p=.069$). El grupo ODAP tuvo menos días de hospitalización y menor cantidad de reuniones familiares ($p < .001$). Sin embargo, no surgieron diferencias significativas en los resultados del tratamiento de 5-años. En el grupo ODAP, el 82% no tuvo síntomas residuales psicóticos, el 86% retornó a sus estudios o a su trabajo de tiempo completo y el 14% obtuvo una pensión por discapacidad. Durante los primeros dos años el diecisiete por ciento recayó y el 19% lo hizo durante los siguientes tres años. El veintinueve por ciento había usado neurolépticos en alguna fase del tratamiento. Se presentan dos casos de ambos períodos para ilustrar este enfoque.

Resumo

Experiencia de Cinco Anos em Pacientes Psicóticos com Primeiro Episódio não Afectivo Usando a Abordagem de Diálogo Aberto: Princípios de Tratamento, Seguimento de Resultados Terapêuticos e Dois Casos

O diálogo familiar aberto (Open Dialogue, OD) e a abordagem de rede preconizam o tratamento domiciliário de pacientes psicóticos. O tratamento envolve a rede social dos pacientes e inicia-se durante as 24 horas após o contacto. A responsabilidade de todo processo terapêutico reside sobre a mesma equipa tanto em contexto ambulatorio como de internamento. O objectivo geral consiste em promover o diálogo com a família para construir palavras para as experiências que ocorrem quando os sintomas psicóticos estão presentes. Na comparação histórica realizada na Lapónia oeste finlandesa, de dados de 5 anos de seguimento de dois grupos de pacientes que tiveram o seu primeiro episódio psicótico não afectivo, foram comparados dois grupos: um antes (grupo API; $n = 33$) e o outro durante (grupo ODAP; $n = 42$) o completo desenvolvimento da abordagem OD. No grupo ODAP, a duração média da psicose não tratada diminuiu para 3.3 meses ($p = .069$). O grupo ODAP teve menos dias de hospitalização e menos encontros familiares ($p < .001$). Porém,

nenhuma diferença significativa se verificou nos resultados terapêuticos de 5 anos. No grupo ODAP, 82% dos pacientes não tinham sintomas psicóticos residuais, 86% retomaram os seus estudos ou empregos a tempo inteiro e 14% recebiam pensões por incapacidade. Dezassete por cento recaiu durante os primeiros 2 anos e 19% durante os três seguintes. Vinte e nove por cento tomavam medicação neuroléptica durante alguma fase do tratamento. São apresentados dois casos de ambos os períodos para ilustrar a abordagem.

Sommario

Un'esperienza di cinque anni di psicosi non affettive al primo episodio nell'approccio dialogo-aperto: principi di trattamento, esiti al follow-up e due casi singoli

L'approccio familiare e di rete del dialogo aperto (OD) mira a trattare i pazienti psicotici nelle loro case.

Il trattamento include la rete sociale del paziente e inizia nelle 24 ore dopo il contatto. La responsabilità dell'intero processo di trattamento è dello stesso gruppo sia nel *setting* ospedaliero, che ambulatoriale.

Lo scopo generale è creare un dialogo con la famiglia al fine di costruire parole per le esperienze che si verificano quando sono presenti sintomi psicotici.

Nella terra lappone finlandese occidentale un confronto storico dei *follow-ups* di 5 anni di 2 gruppi di pazienti psicotici non affettivi al primo episodio è stato comparato, un gruppo prima (gruppo API, $n: 33$) e l'altro durante (gruppo ODAP, $n: 42$), con la fase di sviluppo completo dell'approccio OD.

Nel gruppo ODAP, la durata media delle psicosi non trattate era diminuita a 3,3 mesi ($p: .069$). Il gruppo ODAP ha avuto sia meno giorni di ospedalizzazione, sia meno incontri coi familiari ($p < .001$). Nondimeno nessuna differenza significativa è emersa nei risultati di 5 anni di trattamento. Nel gruppo ODAP, l'82% non ha avuto sintomi psicotici residui, l'86% è tornato ai suoi studi o ad un lavoro a tempo pieno e il 14% ha avuto un sussidio di invalidità. Il 17% aveva avuto una ricaduta durante i primi 2 anni e il 19% durante i successivi 3 anni.

Il 29% aveva usato farmaci neurolettici in alcune fasi del trattamento.

Vengono presentati due casi da entrambi i periodi per illustrare l'approccio.

摘要

開放對話(OD)家庭網絡取向目的為精神病患者的居家介入。此療法將患者的社會網絡納入，並從接洽後 24 小時內開始進行。不論住院病人或是門診病人，整個療程就由其家庭網絡團隊負責。大致目的是在精神病症狀出現時，產生與家庭的對話，好為此經驗建構出語言。在芬蘭西拉普蘭對兩組追蹤五年的首度發病之非情感性精神病者進行歷史性比較。一組(API 組； $n=33$)是在 OD 取向發展完成前，另一組則是過程中進行(ODAP 組； $n=42$)。ODAP 組未經治療的精神病症狀平均持續時間降到 3.3 個月($p = .069$)。ODAP 組同時有較少的住院天數和較少的家庭聚會次數($p < .001$)。然而，治療五年後的結果則未發現顯著差異。在 ODAP 組，82% 沒有殘餘的精神病症狀，86% 重拾學業或正職工作，14% 領殘疾津貼。17% 在頭兩年復發，19% 在而後的 3 年復發。29% 在某些治療階段曾使用抗精神病藥物。研究結果並從兩個階段中選取 2 個案例來闡明此取向。