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Short Communication

Open Dialogue Approach – An Alternative to Neuroleptics or Development of Pharmacologically Cautious Treatment of Schizophrenia?

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Introduction

In Finnish Western Lapland, a family- and network-oriented, comprehensive, psychotherapeutic model of psychiatric care has been developed within public mental health services since the 1980s [1]. It was primarily aimed to optimize treatment of acute psychosis inpatients and their families. A number of nation-wide research projects conducted from the 1960s to 80s by alanen and his co workers led to the formulation of the Need-Adapted Approach (NAA) [2-6]. In the mid-1990s, this further evolved in Western Lapland into the Open Dialogue Approach (ODA) [7]. ODA is based on three core elements: i) family network orientated team treatment, ii) the provision of elaborate psychotherapeutic training for all mental health professionals and iii) carrying out scientific measurements assessing the quality of the care provided in combination with the development of the method [8,9]. During the application of ODA over several years, Finnish researchers formulated seven leading principles that serve as guidelines form entail health practitioners: (1) the organization of a meeting with the patient and his network within 24 hours of the first contact with the psychiatric unit (2) focusing on the patient's social network (3) the formulation of a tailor-made treatment plan adapted to the patient's changing needs (4) the shifting of responsibility of arranging case-specific teams onto mental health professionals (5) maintenance of a psychological continuity by enabling collaboration between personnel from various facilities (6) restoring a sense of security in order to tolerate uncertainty related to the crisis situation (7) supporting the fundamental value of polyphony (every voice present at the joint meeting has a right to speak and to be heard) and dialogicity (seeking dialogue to recognize what was said),which help find a new language that enables patients to describe cryptic experiences. Seikkula et al. presented challenging treatment outcomes, where up to 81% of patients with a first-episode psychosis did not reveal any residual psychotic symptoms at the end of the therapy, while as many as 84% of the treated patients resumed their careers or education [8,9]. Neuroleptics were used less frequently and were prescribed in only 33% of cases during the assessed periods [7]. Even though the described data showed long-term stability in a study conducted after 10 years of introducing the approach [7-9], ODA critics questioned the methodological accuracy of the quantitative analysis (limited cohorts of patients impede the generalization of the outcomes, the use of historical controls hampers the comparison of data obtained by other researchers). They suggested that some of the patients who dropped out may have been treated in more biologically-oriented institutions [10,11]. Many scientists acknowledge the positive impact of ODA on the service culture in the public mental health sector. However, some experts question the extent to which ODA theoretical principles should be followed [11,12].

Aim of the Article

The aim of this paper is to present a peer supported perspective on ODA as an alternative or complementary approach to the Treatment-as-Usual [TAU], which has a psychosocially - based, comprehensive, development approach.

Discussion

In his review of ODA literature, Lakeman argues that the Finnish approach gained much international attention due to the reported reduction of the incidence of schizophrenia and a minimal use of neuroleptics [1,12]. Furthermore, the psychiatric service culture in Western Planeshifted towards a more humanistic and community based approach, which was well accepted by the service users. This was due to the fact that 5-10% of the local population came into contact with psychiatric facilities each year and was deeply engaged in the therapeutic process of their distressed relatives [7]. Thus, patients and their social networks were given the responsibility to draw up a recovery plan, where the patient's choice on treatment was to be taken into consideration. Morrison [13] reveals that multiple uncertainties emerge when discussing antipsychotic pharmacotherapy, due to the overestimation of the efficacy of neuroleptics and the underestimation of their harmful potential. Lehtinen et al. [14] questions the immediate neuroleptisation among patients with first-episode non-affective psychosis, pointing out a similar two-year outcome of an experimental (with a minimal neuroleptic regime) and control (neuroleptics used according to TAU) group. Thereby, he recommends an integrative treatment model where intense psychosocial activities remain at the core of the therapy. Stratford et al. [15] note that focusing on recovery is not an anti-medication attitude towards treatment. However, this does require psychiatrists to show trans-disciplinary team-work and a relational orientation in their approach to the patients. There is some evidence supporting the rationale behind creating early intervention

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teams together with phase specific treatment. However, these findings should be confirmed in methodologically well-designed surveys [16]. It seems important, though, to consider "functional recovery" together with the patient's social network [17]. Family members are periled by the eruption of psychotic symptoms; therefore they seek understanding of the situation. The medical narrative provides an opportunity to better understand a suffering family member, try to help him and understand the treatment. On the other hand, there is social stigma associated with the term "schizophrenia", with people associating the condition with deterioration and chronicity. The patient and his family members are put in an "in-the-corner" lifestyle [18]. Creating an alternative narrative may be the ultimate goal of psychotherapy aiming to re-authorize the patient and deal with the disturbance associated with the "dialogical self-concept" [19,20]. The above-listed ODA principles may assist in creating a secure setting, particularly through polyphony and dialogism, where individuals may work to support the patient [21]. McAdams accentuates the integrative character of auto narration and its fundamental role in giving sense of control over the patient's boundary experience [22]. Handling a psychotic crisis and finding its meaning require quite complex adaptation skills that patients usually lack. It seems of utmost importance that staff support patient networks through gaining competence to deal with severe mental illness. From the authors' point of view, the ODA therapeutic joint meeting may help all those involved adapt to the new situation. This should translate into better treatment outcomes [23,24]. Nonetheless, there is a need for longer and more replicable trials that may assess prolonged treatment results among people with diagnosed schizophrenia.

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