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40 years of Open Dialogue practice and research: Could it also be introduced into the Slovenian mental health care system?

40 let prakse in raziskovanja Odprtega dialoga: Ali ga je mogoče uvesti tudi v slovenski sistem skrbi za duševno zdravje?

»After birth the first thing we learn is becoming a participant in dialogue. We are born in relations and those relations become our structure. Intersubjectivity is the basis of human experience and dialogue the way we live it.« (Seikkula, 2011, p. 179)

Abstract

On the occasion of the 40th anniversary of Open Dialogue (hereafter OD), this article reviews the research on OD from its beginnings to the present day. As OD is an exemplary practice of a biopsychosocial approach, its call to change the biomedical approach that still dominates the field of mental health care, is even more pronounced and urgent. In the Western Lapland in Finland, where OD originated, the transition from the biomedical model to the OD is still an ongoing process, but mental health problems are increasingly being treated in a multidisciplinary manner and with family involvement, so that most of the conversations have moved from the hospital to the patient's home and community without pathologisation and with minimal use of psychiatric drugs. OD has spread around the world in at least 142 teams in 24 countries. Because the practice of OD is community-based and therefore highly dependent on each context of use, its research is conducted using mixed quantitative-qualitative methodologies. In addition to research on the efficacy of OD and on the adherence of different applications of OD to the underlying principles and elements, three other types of research are currently being focused on: studies of the organizational and policy aspects of implementing OD, studies of training in OD,

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and studies of OD as a therapeutic process. In conclusion, the question is raised whether OD could be introduced into the Slovenian mental health care system.

Key words: Open Dialogue, biomedical approach, biopsychosocial approach, mental health care, mental disorders, community-based multidisciplinary teams, social networks

Povzetek

Ob 40. obletnici Odprtega dialoga (v nadaljevanju OD) je v tem članku predstavljen pregled raziskav o OD od njegovih začetkov do danes. Ker je OD zgledna praksa biopsihosocialnega pristopa, je njegov poziv k spremembi biomedicinskega pristopa, ki še vedno prevladuje na področju skrbi za duševno zdravje, še toliko bolj izrazit in nujen. V Zahodni Laponski na Finskem, od koder OD izvira, prehod od biomedicinskega modela k OD še vedno poteka, vendar težave in motnje v duševnem zdravju vse bolj obravnavajo multidisciplinarno in ob sodelovanju družine, tako da večino pogovorov opravijo na bolnikovem domu in v njegovi skupnosti brez patologizacije in z minimalno uporabo psihiatričnih zdravil. OD se je razširil po vsem svetu v vsaj 142 time v 24 državah. Ker je praksa OD skupnostna in je zato zelo odvisna od posameznega konteksta uporabe, raziskave izvajajo z uporabo mešanih kvantitativno-kvalitativnih metodologij. Poleg raziskav o učinkovitosti OD in o zvestobi temeljnim načelom in elementom OD pri različnih načinih uporabe so trenutno najpogostejše tri vrste raziskav: študije organizacijskih in političnih vidikov izvajanja OD, študije o usposabljanju iz OD in študije OD kot terapevtskega procesa. V sklepu izpostavimo vprašanje, ali bi bilo mogoče OD uvesti v slovenski sistem skrbi za duševno zdravje.

Ključne besede: Odprti dialog, biomedicinski pristop, biopsihosocialni pristop, skrb za duševno zdravje, duševne motnje, skupnostni multidisciplinarni timi, socialne mreže

1. Introduction

In November 2024, the Slovenian translation of the book *Dialogical Meetings in Social Networks* by Jaakko Seikkula and Tom Erik Arnkil (2006, 2023) was published (Figure 1). This is the first book in the Slovenian language on the ‚Open Dialogue approach' (hereafter OD), which is an empirically based biopsychosocial approach to mental health care, which began in Finland in 1984 and has become an important international movement (Putman & Martindale, 2022). OD has not only improved psychiatric care for people with psychotic and other mental disorders, but has also increased social capital in the areas studied and mutual trust between the general population and psychiatric services (Aaltonen et al., 2011). One of the key messages from the Finnish experience is that the social networks in which the patient or identified client is embedded need to change, and that the biomedical model has detrimental effects precisely because it attributes pathology to the individual, thus neglecting the influence of the social context.

From the outset, Seikkula and his co-workers researched the effectiveness and the efficacy of OD (e.g. Seikkula, 1994, 2002; Seikkula et al., 2001, 2003, 2006, 2011; Seikkula & Arnkil, 2006; Bergström et al., 2018). As early as 2006, Seikkula et al. (2006) provided an impressive summary of surprisingly good outcomes: at 5 years after completing treatment, 82% of the participants had not developed chronic psychotic symptoms, 86% were working full-time or studying, and only 29% were taking antipsychotic medication. Not only that, but after 20 years of OD, the incidence of schizophrenia in the area had fallen by four-fifths. But even today, although the positive results have been confirmed again and again, for example by a comparison with a control group over a period of 19 years (Bergström et al., 2018), they still seem incredible to most mental health professionals, who, when asked about the prognosis of psychotic disorders, continue to give a much more pessimistic answer: that one third of patients make a full recovery, one third remain more or less functional on regular neuroleptics, and one third remain permanently disabled, unemployable and excluded from the wider social environment, albeit on high-dose neuroleptic maintenance therapy. It is precisely this pessimistic view that the mainstream psychiatric establishment uses to emphasize the importance of taking medicines for a long time, although there are enough studies to prove the opposite - that long-term psychopharmacotherapy worsens treatment course and outcome for people who have been labelled with a categorical psychiatric diagnosis (Moncrieff, 2008, 2013; Whitaker, 2004, 2010).

This belief that psychotic and most of other mental disorders, as defined in DSM and ICD systems, are like physical illnesses, resists the growing evidence, revealed by OD as well as other contemporary practices of the biopsychosocial approach, that the relatively poor outcomes of classical psychiatric treatment are related to an inappropriate biomedical model that increases pathologisation, medicalization, medicamentalization, institutionalization and stigmatization (Bentall, 2009; Blazer, 2005; Čeh, 2024; Davies, 2012, 2013; Flaker, 2012, 2023; Fuller Torrey, 2014; Glasser, 2003; Gotzsche, 2015; Jensen et al. 2006; Lewis, 2009; Makovec, 2019; Miškulin, 2016, 2017; Moncrieff, 2008, 2015; Možina, 1998; 2016a; 2019ab; 2020; 2023, 2024abc; Paris & Phillips, 2013; Runswick-Cole et al., 2016; Scull, 2015; Shorter, 2015, 2021; Slatnar, 2012; Šugman Bohinc & Miškulin, 2024; Timimi & Leo, 2009: Ule, 2009, 2012; Vec, 2024; Whitaker, 2004, 2010).

In the report commissioned by the Committee on Bioethics (DH.BIO) of the Council of Europe many good practices that reduce the use of medication and coercive measures are described: the Basal Exposure Therapy combined with Complementary External Control in Norway, the Trieste model and the community mental health initiative in Italy, the Mental Health Mobile Units in Greece, the Weddinger model in Germany, the Hugarafl organisation in Iceland, the Personal Ombud Programme in Sweden, the Family Group Conferencing, the High Intensity Care Units and the Patient-led action plan to appeal compulsory treatment orders in the Netherlands, the ‚coercion-free first' approach in the US and the UK, the Safewards model in England, the TANDEMplus Mobile Crisis Support in Belgium, the Peer to Peeer Mediator and the Cizitizen Psychiatry – East Lille Public Psychiatry in France, the Peer Support an the Peer Workforce initiatives that are organized internationally (e.g. Hearing Voices Network, Intentional Peer Support, BE RIGHT – Multinational Training Initiative for Health and Social Care Professionals in Mental Health Settings), the Respite Houses like Bochum Crisis Rooms in Germany, Soteria House in Sweden and internationally and Wegalaufhaus in Germany, etc.) (Council of Europe, 2021).

Unfortunately, not only experts working to develop community-based forms of support (e.g. Flaker, 2023; Možina, 2002; Šugman Bohinc & Miškulin, 2024) and to integrate psychotherapy into the mental health care system (e.g. Možina, 2021; Barat, 2023; Oravecz, 2023; Kamenarič, 2024; Levstik, 2024), but also experts from the WHO, have collectively concluded that Slovenia is lagging behind many European countries in shifting the focus of mental health care from a biomedical to a biopsychosocial approach (WHO, 2020).

As OD is a very successful example of a biopsychosocial approach, but is difficult to implement due to the predominance of the biomedical approach, let us take a closer look at the differences between the two (Table 1).

2. Biomedical approach and biopsychosocial approach

The biomedical approach, based on the dualism of body and mind (spirit), began to take hold with the development of modern medicine from the mid-19th century onwards. It defines health as the absence of disease, and seeks the origin of disease in the body, so that in the case of mental disorders, it is primarily a disorder of biochemical and/or neurophysiological processes in the brain. Diagnosis is based on a specific identification of this bodily cause and is the basis for planning and implementing a specific form of therapy, which is effective in many cases of physical illness (e.g. appendicitis followed by surgical removal), but not in cases of mental disorders and illnesses, because psychosocial factors

are not taken into account (Možina, 2024abc). The biomedical approach has led to (sub)specialization in the organization of service provision, leading on the one hand to excessive fragmentation and on the other hand to an excessive standardization of treatment procedures, where the ‚golden goal of medicine' of one treatment being appropriate for all patients, regardless of context, is attempted to be realized. Treatment is focused on the individual or on a single organ, to the exclusion of the patient's close and wider social networks (Možina, 2021).

Table 1

Differences between biomedical approach and biopsychosocial approach.

BIOMEDICAL APPROACH	BIOPSYCHOSOCIAL APPROACH
Pathologization and medicalization of mental problems and disorders, treatment does not include the psychosocial dimension of the person.	**The patient is the main actor in the treatment, so their social environment is involved.**
Mental disorders are illnesses similar to physical illnesses, where the cause is in the body.	Mental disorders are not physical illnesses, but are mostly psychosocial, with physical consequences.
A medical categorical diagnosis (e.g. 'depression', 'anxiety disorders', 'personality disorders', 'psychosis', 'ADHD', etc.) is essential to start treatment. A diagnosis focused on pathology, deficits, problems, issues, deficits and disorders is crucial for successful treatment. Immediate response means convincing the patient as soon as possible that there is a disease and that psychiatric medication should be started as soon as possible.	Categorical diagnoses are not only unhelpful, they are harmful. A holistic assessment of the patient in their social environment (family, community) is needed. In this context, an assessment of the patient's resources (biological, psychological and social), and abilities with the aim of empowering the patient and those close to them is of paramount importance. The diagnostic assessment must be balanced: in addition to assessing the problems, it must include everything that is good and healthy in the patient and in their life. It must give the patient hope, trust and faith for improvement/healing. Immediate response means starting to treat the patient AND their social network as soon as possible, and as much as possible without medication.
The cause is in the body (in the brain, in a biochemical imbalance), psychiatric drugs restore the biochemical balance and are therefore a specific form of treatment.	Mental disorders are multidimensional, involving a combination of biological, psychological and social factors. The hypothesis that biochemical imbalances in the brain cause mental disorders and that drugs restore biochemical balance has never been scientifically validated and remains a myth.

BIOMEDICAL APPROACH	BIOPSYCHOSOCIAL APPROACH
A specific diagnosis allows specific drug treatment. There is no time for a good relationship with the patient; what matters most is to convince the patient of the given diagnosis and to ensure that the patient takes their medication regularly as prescribed by the doctor.	Psychiatric drugs can relieve symptoms but do not treat the underlying causes of mental health problems, and are mainly useful for acute conditions for a short period of time. The key to recovery is the patient's motivation to activate all resources and to make the effort to work on therapeutic change. Contextual factors are crucial for healing: among these, a trusting therapeutic relationship and the support of a social network in which the patient feels safe, understood and compassionate stand out.
It is the doctor who knows what is wrong with a person and what treatment is needed. The patient's assessment is subjective, unreliable, unprofessional. The therapist must rely primarily on objective findings of physical and mental parameters (e.g. laboratory tests, brain scans, clinical psychological findings). The main mode of intervention is somatic, e.g. with pills, injections and other ways of intervening in the body.	The only one who can find and be able to find a solution is the patient, and the therapist can only help by getting to know the patient and their life situation as holistically as possible, through understanding and empathy. The therapist continuously asks the patient about their understanding of the problems, the resources, the therapeutic process, the relationship with the therapist, possible solutions and progress, and guides the therapeutic process based on the patient's feedback. The main mode of intervention is dialogue, establishing multiple voices, perspectives and intersubjective space.
The doctor should be as neutral as possible, objective, emotionally distant, and hide their subjectivity. When assessing the therapeutic process, they should rely primarily on their professional judgement, not on that of the patient. It is undesirable and unnecessary for doctors and other professionals involved in the treatment to reflect on their work and their interactions. Supervision is not necessary. Meetings with patients are closed, as inaccessible as possible to relatives and the wider social network.	The therapist's qualities are one of the key factors in successful treatment. Research confirms that therapists who are warm, kind, accepting, persistent, empathic, positive, flexible, adaptable, verbally skilled, understanding, reflective, encouraging, flexible, authentic, persuasive, curious, teachable and humble have the best success. Regular supervision is also essential for ongoing reflection. In line with the basic OD principle of 'nothing about us without us', meetings with the patient are open to the participation of relatives and the wider social network.
The patient is treated as separate from their social context, and the spiritual dimension plays no part.	The unit of treatment is not the patient, but the individual and the social environment (family, work environment, friendship networks), including the spiritual dimension of the patient.
Treatment must be based on certainty: a certain diagnosis and a certain treatment. The doctor and medicine are the guarantors of certainty.	Treatment is an unpredictable process, so it is crucial that helpers allow for uncertainty.
Body-mind dualism, the psyche can be considered separate from the body and vice versa.	Body and mind are inextricably linked, requiring holism, a holistic approach.

BIOMEDICAL APPROACH	BIOPSYCHOSOCIAL APPROACH
Health is the absence of disease. The aim of treatment is to reduce, alleviate or eliminate symptoms. It is important to make the patient as adapted and functional as possible, even if their problems are due to the harmful influence of the environment.	Health is a dynamic balance of physical, mental and social well-being. The aim of treatment is first and foremost to improve quality of life and, as far as possible, to improve unpleasant symptoms. If the patient's problems are the result of a harmful environment, the symptoms are understood as a healthy response to an unhealthy environment.

The biopsychosocial approach has evolved from broader cultural currents, traditional healing practices and humanism. It emphasizes holism over mind-body dualism, defining health as a state of physical, mental and social balance. It explains both health and illness as the result of an interplay of biopsychosocial factors in a multicausal manner. Instead of categorical psychiatric diagnosis, which by scientific and professional criteria is useless for treatment and even harmful, as it contributes to excessive pathologization, medicalization and stigmatization, it develops ways of assessment and diagnosis that take into account the individual in their social and cultural context. It seeks to integrate subspecialized and fragmented forms of treatment, and to tailor the way in which treatment is provided to the needs and characteristics of each individual patient and their particular social environment (Možina, 2024abc).

3. Open Dialogue as an exemplary practice and research of a biopsychosocial approach

Putman (2022, pp. xxi-ii), in the introduction to the monograph on OD (Putman & Martindale, 2022), points out that research and the testimonies of thousands of mental health service users around the world show that reliance on a biomedical approach reinforces vicious cycles of stigma, discrimination, social exclusion and coercion. People who hear voices or experience other symptoms that are classified as psychotic are particularly vulnerable to discrimination, institutionalization, coercion and over-medicalization (Možina, 2019ab). In the name of medicine and psychiatry, their human rights are often violated. It is OD, however, that is one of the leading and most promising practices of the biopsychosocial approach in the world today (Seikkula, 2022). As a major strength of OD from its inception to the present is that it has developed as practice and research at the same time, what follows is an overview of research on the development and current status of OD practices around the world.

Figure 1

Jaakko Seikkula, clinical psychologist and family therapist, who was a member of the team that developed the Open Dialogue approach in Western Lapland, Finland, from the early 1980s until 1998. In November 2024, the Slovenian translation of the book *Dialogical Meetings in Social Networks* **by him and Tom Erik Arnkil (2006, 2023) was published.**





The origins of OD began in the early 1980's in the psychiatric hospital Keropudas in Western Lapland in Finland (Seikkula, 1994). Jaakko Seikkula (Figure 1), one of the original team members[2], who has contributed most to the development of OD from its beginnings to the present day, describes an event that represented the first step on the path from a medical to a contextual model:

> „In the process towards an open system, the most important step - in which families' and professionals' cooperation had a central role - was taken in 1984. Instead of a division into closed treatment-planning meetings by the staff and then family therapy sessions according to the plan, open meetings were put into practice for both planning and treatment. It was decided to have the patient present from the very beginning of his/her treatment. This meant, literally, a practice in which the staff did not plan in advance the meeting or the proposals for the patient concerning treatment decisions. The family was invited into the joint meetings in every case without a specific indication for family therapy. This practice of therapy meetings had been initiated in Turku University Hospital (in Finland) a year before by Professor Yrjö Alanen and his team." (Seikkula & Arnkil, 2006, p. 21)

2 In addition to Seikkula, members of the original team that started to develop the Open Dialogue approach at Keropudas Hospital were: Jukka Aaltonen, Brigitta Alakare, Jyrki Keraenen in Kauko Haarakangas (Seikkula & Olson, 2003).

The transition from the biomedical model to OD has, of course, been gradual. OD is still an open and evolving project of clinical practice and research. In the context of OD, psychiatric crises were increasingly treated in a multidisciplinary manner and with family involvement, so that most of the conversations moved from the hospital to the patient's home and community. Conversations that started immediately at the onset of the first psychotic episode could involve as many as ten, twenty or more people who were important to the patient, ranging from professionals, family members, relatives, friends and all those who had an interest in the patient's well-being. All key issues would be decided in dialogue or polylogue. Whether, when and how much medication a patient will take is not decided by the psychiatrist alone, but the decisions are co-created in conversations. OD has received strong support in Northern Europe, as Seikkula, together with Norwegian psychiatrist and psychotherapist Tom Andersen (1987), has set up an international network of groups in Russia, Lithuania, Latvia, Estonia, Norway, Sweden and Finland that have applied OD to acute psychiatric disorders.

In terms of its original concepts, OD represents an application of the Batesonian tradition and Bakhtin's concept of dialogue (Seikkula & Olson, 2003). OD is designed to create a shared language that permits the meaning of the person's suffering to become more transparent within the immediate network. The Bakhtinian idea of dialogue (Bakhtin, 1981) and its adaptation to the psychotic situation derive from the Batesonian tradition that sees language and communication as primarily constitutive of social reality (Bateson, 1972/1987). Constructing words and establishing symbolic communication is a voice-making and identity-making process that occurs jointly between people. Crises become an opportunity to make and remake the fabric of stories, identities and relationships that construct the self and the social world. OD thus translates Bakhtin's concept of dialogism into a co-evolving process of listening and understanding.

Despite the dominance of the biomedical approach, the positive results of OD have attracted the attention of many beyond Finland's borders, so that, according to a retrospective study in 2022, OD has been taught in at least 142 teams in 24 countries, e.g. Norway, Denmark, Portugal, Poland, Japan, Belgium, the UK, Italy, Germany, Holland, Israel, Spain, the USA, Australia, India, Latin America, etc. (Pocobello et al., 2023). The key feature that is maintained throughout is that all treatment decisions are made in the presence of the patient/user and their wider social network, and that psychotherapeutic ways of facilitating dialogue within this social network have an important place in the spectrum of help.

A variation of OD that has been developing in recent years is ‚Peer-supported Open Dialogue' (POD), where an explicit role of peer support workers has been

added (Razzaque & Stockmann, 2016). These are paid professionals, who have also gained their expertise from their own experience. They therefore use experiential knowledge „gained from experiencing psychological distress" (Bellingham et al., 2018, p. 1575). In addition, POD enforces the call for transparency „nothing about us, without us" (nothing about users, without users), which stems from the recovery movement (Hopfenbeck, 2015).

The introduction of OD into mental health care systems in all the countries mentioned above is done in two main ways: by creating a culture of dialogical communication between professionals, users, family members and other members of the users' social network, and by organizing community-based multidisciplinary teams for outpatient treatment. These changes are fully in line with the recommendations of the WHO, which promote greater availability, coordination and frequency of service use and the mobilization of community resources, on the assumption that such measures will lead to a significant reduction in hospital admissions and the cost of care, and a significant improvement in recovery rates (WHO, 2013). OD works even in closed psychiatric wards by significantly reducing the use of coercive measures, as demonstrated by the experience in the high-security psychiatric ward of Akershus University Psychiatric Hospital in Norway (Jacobsen, 2018; von Peter et al., 2019).

4. Research on Open Dialogue

As the practice of OD is community-based and therefore highly dependent on each context of use, its research cannot be conducted using quantitative methodology alone, but by using mixed quantitative-qualitative methodologies (Freeman et al., 2019; Buus et al., 2021), including multi-site observational studies used to test feasibility and efficacy (Harding et al., 1987; Seikkula et al., 2006):

- OD experiences and outcomes are examined through a variety of surveys, including self-report scales from service users (and family/social network members) (e.g. on quality of life or perceived satisfaction with network meetings and the service in general).
- Measures of the ‚core elements' of OD have been developed, that can be used to measure the adherence of practitioners and organizations to OD practice (Olson et al., 2014).
- Methods for evaluating OD without structured questionnaires to measure outcomes or adherence include descriptive case studies of services or organizations and user case reports.
- Evaluating the process of OD rather than the outcomes per se has led to the use of a range of qualitative methods, such as focus group discussions (with clients and professionals), recorded practitioner dialogues, group reflections, practitioner self-reports, subjective reflections, and narratives of personal experiences (e.g. Rober, 2005; Gromer, 2012; Bøe et al., 2015; Cubellis, 2020; Dawson et al., 2021).
- Some OD studies have been conducted as action research to capture evolving OD programmes (Hopper et al., 2020).
- Long-term group ethnographic research by practising anthropologists offers deep qualitative insights into the processes and effects of OD (Pope et al., 2016; Cubellis, 2022). This research is based on a phenomenological orientation to OD, including attention to its affective and embodied aspects, as well as the social, institutional and material context of OD services (Cubellis et al., 2021).

In addition to empirical studies, conceptual work has always been a focus of research, contributing to the still developing theory of OD (e.g. Andersen, 1987; Seikkula, 2003, 2011; Seikkula et al., 2003; Shotter, 2015). Such analytical and philosophical considerations are not limited to addressing OD in a narrow sense, but also to making connections with other psychosocial approaches, like harm reduction projects (Hall, 2012, 2016), Hearing Voices Movement (Baker, 2017), psychoeducation (Kay et al., 2021), etc. It is also possible to integrate different psychotherapeutic approaches or methods into OD, e.g. systemic (family) psychotherapy (Možina & Šugman Bohinc, 2004; Možina, 2010), solution-focused psychotherapy (Berg & Miller, 1992; Možina & Rebolj, 2020), psychoanalysis (Saks, 2021), reality therapy (Glasser, 2003), CBT (Lincoln & Brabban, 2021), narrative therapy (White & Epston, 1990), mindfulness and acceptance based therapies (Johns et al., 2021), etc. Integration of different therapeutic methods into a joint treatment process of OD means that methods do not compete with each other, but support each other.

For example, Anticipation Dialogues (hereafter referred to as AD), a method developed by Tom Arnkil and Esa Eriksson, can be integrated into OD for less acute situations where there is a need to find ways to coordinate the actions of multiple participants who are dissatisfied with what others are doing, or where coordination is lost due to a lack of transparency (Seikkula & Arnkil, 2006). AD is conducted by a pair of facilitators who are outsiders to the matter under discussion. They ask each participant a series of future-oriented questions, called ‚recalling the future', in order to create a common plan of action and a better balance between problems and solutions. Arnkil and Eriksson were inspired by the solution-focused miracle question[3] (de Shazer, 1994). But instead of

3 The premise of the miracle question is to build a scenario where the client imagines going home at the end of a therapy session, does their nightly routine and then goes to bed. At some point during the night, the client's problem that brought them to therapy or consultation is completely solved — it's a miracle! However, it has happened while the client is sleeping and unaware. So, when the client wakes up in the morning, how do they notice that the problem has been solved? (Miller & Berg, 1995)

avoiding all problem talk, they engaged in the analysis of subjective problems and emphasized the active role of the subject. In recalling the future, ‚ifs' were left out of the imagination of the future: instead of asking ‚if things were OK', people were encouraged to imagine ‚how things are for you now that they are OK'. The present was ‚taken' into the future, and the journey there was considered in retrospect. In addition, people's own initiative was emphasized by asking ‚what did you do to get there? And subjective worries were addressed - problems that people felt they were facing - by emphasizing the elements that alleviated those worries. In this way, influences from resource-oriented and solution-focused therapies merged with Vygotskian activity theory.

The question of how differences in the design and implementation of OD can affect outcomes is crucial as OD adapts to local health care systems and unforeseen circumstances. Given the increasing diversity, the empirical question arises whether OD is a clearly delineated intervention or a broad approach manifested in different local forms, and to what extent all these uses of OD are faithful to the original. In order to explore the extent to which different OD projects are faithful to the seven original principles (five organizational principles: immediate help, social network perspective, flexible adaptation to specific and changing needs, taking responsibility, ensuring psychological continuity; and two practice-related principles: tolerating uncertainty and being dialogical/polilogical), the last two practice-related principles are built upon with more detailed descriptions of the twelve elements of OD adherence (Olson et al., 2014):

1. two or more therapists participate in the team meeting;
2. participation of family and social network;
3. using open-ended questions;
4. responding to client utterances;
5. emphasizing the present moment;
6. eliciting multiple viewpoints;
7. use of a relational focus in the dialogue;
8. responding to problem discourse or behaviour in a matter-of-fact style and attentive to meanings;
9. emphasizing the clients' own words and stories, not symptoms;
10. conversation amongst professionals (reflections) in the treatment meetings;
11. being transparent;
12. tolerating uncertainty.

These twelve elements are not separate, but often overlap and co-occur in clinical practice. With regard to the criterion of dialogical communication, it is worth pointing out that monological communication has also been partially

‚rehabilitated' since 2006. While in the book of Seikkula and Arnkil (2006) it is portrayed as exclusively negative and undesirable, Olson et al. (2014, pp. 6-7) point out that monological sequences in dialogue are also indispensable for a fuller understanding of the situation. By monological communication they mean sequences in which the therapists themselves introduce conversational topics. Such sequences can be designed to elicit new information, give advice, plan treatment, make practical arrangements or open up new topics for conversation that are not based on what the client or another participant has previously said. In an OD meeting, up to a third of the conversation may be monologue in order to stay adherent to the principles and elements of OD and to conduct an effective meeting. Monological communication can refer to the nature of communication within a social network or communication between professionals and the network.

Based on the seven original principles and twelve elements of OD, Melissa Lotmore (2019) in her doctoral research developed what she termed the Dialogic Practice Adherence Scale (DPAS), the use of which is being tested simultaneously in the USA and the UK (Lotmore et al., 2023). An international study on the feasibility of OD, called HOPEnDialogue, is currently underway and aims to establish an assessment framework for the international evaluation of OD outcomes (Alvarez et al., 2021). It is testing the validity and reliability of the DPAS scale with a view to, among other things, using it in a large English randomized controlled trial (the Open Dialogue - Development and Evaluation of a Social network intervention for Severe mental Illness = ODDESSI study) in multiple sites to assess the clinical and cost-effectiveness of OD compared to a conventional biomedical approach for people presenting to one of six selected community mental health services in a psychotic crisis. A research protocol has already been developed (Pilling et al., 2022), and if OD is shown to be more effective than a biomedical approach, OD will be systematically introduced into the English community mental health care system. The main outcome measure in the study will be the time to relapse from an acute psychotic episode, with recovery factors and service use monitored. Participants will be followed up for two years and data will be collected from electronic health records and interviews conducted by the researcher. The analysis will compare outcomes between groups and will track potential mediators of impact, in particular shared decision-making and the quality and size of the social network. In particular, OD participants will be asked about their experiences of shared decision-making, burden and satisfaction.

In addition to research on the efficacy of OD and on the adherence of different applications of OD to the underlying principles and elements, three other types

of research are currently in focus: studies on the organizational and political aspects of the introduction of OD, studies on training in OD, and studies on OD as a therapeutic process (Mosse et al., 2023). Organizational studies for specific countries or health systems mainly include case studies. They point to the barriers related to excessive bureaucratization in health and other social sectors involved in the mental health care system, to which OD has to adapt. Studies on the bureaucratic aspect include descriptions of clinical governance systems, risk management, descriptions of performance indicators and descriptions of problems with professional hierarchies. Indeed, OD necessarily entails (and depends on) institutional changes, with a sometimes radical redefinition of the concept of accountability. In its political dimension, OD requires a rethinking of the impact of institutions, which can be the real strongholds of the biomedical model, and necessarily triggers a movement for change, for a more humane and more flexible response of existing institutions to the experiences and demands of users, families and communities, many of whom have already had bad experiences with psychiatry. Studies on the prescribing of psychotropic medication in OD and non-OD treatment networks are also of interest (Alakare & Seikkula, 2022).

Studies on OD training in particular describe how its principles are taught through the development of dialogical skills, which e.g. include listening, embodiment, presence or mindfulness, specific ways of questioning and reflection, etc. There is also a growing body of research on the experiences and organizational conditions, opportunities and contradictions for POD in different service structures (Razzaque & Stockmann, 2016; Hendy et al., 2023; Lorenz-Artz et al., 2023).

Studies of OD as a therapeutic process are dominated by detailed descriptions of dialogical interactions through which participants seek to make meaning and sense of the crisis in which they find themselves. As OD is a social network activation approach, the descriptions are focused on:

- the relational dynamics of network meetings and their impact on outcomes;
- the encouragement of different voices and perspectives of the participants;
- the way in which the testimonies of the people at the centre and their family members enter into dialogue with psychiatric knowledge, diagnosis and decision-making.

In this way, a deeper understanding is gained of the structure and organization of OD networks, the involvement of the family (or several families) and the dynamics of the relationships that develop. They are shaped by family systems and socio-cultural environments in ways that are found in OD practice and involve specific challenges, e.g. when violence is present. When OD is extended to different settings, opportunities for developing cultural identity, kinship

systems and different embodied, symbolic and linguistic repertoires emerge in the joint meaning-making and promotion of social connectedness involved in the transition from crisis to recovery.

5. Is Open Dialogue also appropriate for Slovenia?

The publication of the Slovenian translation of Seikkula and Arnkil's book raises a tiny hope for better times in Slovenian mental health care and the prospect that more and more mental health professionals will recognize the value of OD and begin to introduce it into our mental health care system. Although the dominance of the biomedical model is a global phenomenon, Slovenia is one of the countries where the orthodox psychiatric establishment maintains a more rigid version of it (Levstik, 2024). For example, while the Clinical Psychology Division of the prestigious British Psychological Society (BPS), which represents the very top of the clinical psychology profession, warned in 2013 of the shortcomings and pitfalls of traditional psychiatric diagnosis and called for a move away from it, orthodox Slovenian psychiatrists and clinical psychologists insist on categorical diagnostics as the only possible starting point for successful treatment (Možina, 2024ab). As the WHO Expert Commission (2020) notes, this is followed by overprescription of psychotropic drugs and inpatient rather than community-based treatment, making deinstitutionalisation in Slovenia much less effective and rapid than elsewhere (WHO, 2020). Orthodox psychiatrists and clinical psychologists also try to prevent psychotherapists from being integrated into the public health system in any way (Možina, 2023b; Oravecz, 2023).

After the Slovenian Parliament adopted the Resolution on the National Mental Health Programme 2018-2028 in March 2018, we have for the first time since we became an independent country a strategic document that, based on the WHO recommendations, should accelerate the shift of focus from a biomedical approach to a community-based biopsychosocial approach (PISRS, 2018; Vinko et al., 2019). In fact, over a period of six years, around thirty Mental Health Centres for adults as well as for children and adolescents have been established across Slovenia, strengthening the offer of psychiatric and psychosocial forms of support at the primary health care level (NIJZ, 2021). Unfortunately, if we still find that Slovenian psychiatric hospitals are the unshakeable fortresses of the biomedical approach, then apart from the understaffed and underfunded community psychiatric treatment programmes (e.g. Kaurič et al., 2012), the new structures of the Centres for Mental Health are more than suitable for the introduction and development of OD.

One of the key messages of the Finnish experience is that the social networks in which the patient or the identified client is embedded must change and that the biomedical model has harmful effects precisely because it focuses on the individual and thus neglects contextual resources. In the broadest sense, it is the quality of care for people with severe and enduring mental health problems that is one of the most sensitive indicators of the degree of democracy in society. This is why psychiatry and psychotherapy are particularly exposed in helping these people, either as a shining example of democratization, or as a conservative practice that does not cure but contributes to the stifling of social diversity through pathologization. If we take it that the pragmatic measure of democracy is to increase social diversity and to integrate differences into an ever broadening tapestry (Rorty, 1999), then it is acting undemocratically and, through the increasing consumption of psychopharmaceuticals, repressively. Chemical repression, which occurs when it becomes the main mode of assistance in the absence of psychosocial measures, has a milder outward appearance than the repressive approaches of the pre-pharmacological era (led by the infamous lobotomy approach), but is all the more dangerous for that very reason (Možina, 2023ab; Oravecz, 2023; Shorter, 2021).

However, when introducing OD into the mental health care system, it is good to ask the fundamental question posed by Seikkula (2011): is it (only) about developing a way of working or (also) a way of living? Seikkula answers that developing OD is on the one hand simple, because it is not only a psychotherapeutic approach, but life itself is an ongoing dialogue. On the other hand, it is challenging because life is complex and difficult. As long as we see OD as a tool, e.g. as a hammer with which to successfully hammer nails, without having to change ourselves, it will not bring about significant change. OD requires a deep personal change of the user, i.e. a change of the one who wields the hammer. In order to engage in a different way with the people who seek help, professionals must first change themselves, develop their capacity for dialogue. Developing dialogical communication requires a constant breaking down and stepping down from a position of power, and goes hand in hand with openness, insecurity and humility. It opens up a space for understanding and compassion for the other.

In Slovenia, we, mental health professionals, still have a long way to go in developing open dialogue and a biopsychosocial approach. A lot of open-mindedness, open-heartedness and courage will be needed to face the discomfort of uncertainty, that inevitably comes with cooperation, as Piaget (1995) also pointed out. We can never know where cooperation will lead to, because it involves equality between different personalities, autonomy, open dialogue, rationality, reciprocity, contradiction, policentrism, mutual confirmation, the

need for proof, inventing the path while walking, heterostasis, distinguishing between facts and ideals, and accepting not knowing where cooperation will lead.

6. Epilogue

Writing and reading research review articles takes us away from the vividness of clinical experience, so in this epilogue I return to a case from our psychiatric and psychotherapeutic practice at the SFU Ljubljana Outpatient Clinic (Možina, 2016b). There we are confronted with (too) many similar cases that testify to the harmful consequences of the biomedical model. It is the experience with such cases that has been the basis and motivation for this article, as our work is based on a biopsychosocial approach, which also includes elements of OD. Although our team was not trained in OD, our approach was developed within a similar framework based on the Batesonian tradition of a systems and of a community-based approach (Kobal & Možina, 2004; Možina, 2002, 2010, 2011, 2014, 2020ab, 2023c, 2024ab; Možina et al., 2011; Možina & Stritih, 1998; Možina & Šugman Bohinc, 2004; Verbnik & Možina, 2021).

At present (December 2024) we treat around 650 cases, 20% of which are children and adolescents and their parents. We are contacted on a weekly basis by parents who are not satisfied with the biomedical treatment their children are receiving or who are unable to receive it because of the long waiting times, currently between one and two years. Their complaints are always the same, namely that their children and they themselves have not been able to develop a trusting and cooperative relationship with the health professionals in the public health system, and that after a while they do not see the point of either the diagnoses or the medications, because they make their problems worse. Because our clinic operates as a private institution in the free market, all clients have to pay for our treatment themselves. That‘s why we‘re also pushing for a law that would regulate psychotherapy as an independent profession, and allow psychotherapists to be included in the health system, which would allow our clinic to be licensed, making free treatment available to all those who can‘t afford it now.

I received a call from the mother of my 12-year-old daughter, Luisa, who had been admitted to a child and adolescent psychiatric unit after attempting suicide by cutting her veins. She had been in outpatient treatment with a paedopsychiatrist for about a year because of frequent cutting with a razor blade, and had been admitted to the paedopsychiatric ward three times for self-harm and suicidality (once she had attempted suicide by taking a large dose of an antipsychotic medication that she otherwise took regularly). Immediately

after the first contact with the girl and on the basis of a clinical-psychological examination, the official report described the following symptoms of depression and anxiety (verbatim quote):

„depressed and low mood, quiet speech, downward gaze, feelings of guilt and inferiority, listlessness, ineffectiveness, disinterest, constant fatigue, sleep disturbances with nightmares (she sometimes woke up at night as if she had been electrocuted), headaches, abdominal pain, disturbances in concentration and attention (daydreaming), impulsivity with occasional disorganisation, irritability, increased and accumulated internal tension, lowered frustration tolerance, excessive self-focus and associated poorer sensitivity to the needs of others, excessive focus on negative aspects of herself, rigid coping with stress, weaker capacities and less adequate coping strategies for stress and impulsivity, suppressed emotions, lowered self-protective behaviour, overexposure to risky situations, pessimism, excessive achievement drives resulting in constant frustration, disorganised, inconsistent and illogical thinking with drawing of wrong conclusions, preoccupation with internal painful content, suicidal ideation with high suicide risk, poor self-image, body image dissatisfaction, low self-esteem, self-hatred, nail biting, excessive skin scratching and excessive use of electronic screens."

The assessment of cognitive functioning described a markedly inhomogeneous profile of her achievement test scores and average but highly variable mental performance, average vocabulary, average abstract reasoning skills and low practical information. The psychologist felt that she solved tasks too quickly and impulsively, which sometimes led her to answer too quickly, without thinking carefully, not thinking deeply enough and making mistakes as a result.

Of the good qualities, the psychologist described only two: that the tests showed that Luisa's general outlook and cognitive judgement (which includes non-verbal reasoning, visuomotor and visuospatial skills) were strengths, and that the girl herself said that she was a good listener, attentive to others, a quick learner, friendly, very capable and adaptable.

This ratio of terms with a negative to positive connotations is typical in the findings of Slovenian clinical psychologists and reflects their orientation towards pathology and pathologisation, which is one of the main features of the biomedical model. Such a diagnosis is considered to be the only professionally sound basis for further effective treatment. It does not take into account that a single visit by an unknown person, in this case a psychologist, who is also perfectly qualified to find out as much as possible about the patient's problems, difficulties, disorders, illnesses, deficiencies, distresses and deficits in a scant hour with a bunch of questions, contributes significantly to the patient's anxiety

and tension, especially if she is an adolescent with a still fragile sense of self--worth, is not taken into account. Nor does any of the proponents of this type of diagnostics care about the demoralising and frightening effect that such a professional opinion has on parents and their children when they read it.

On the basis of a clinical impression and psychological tests, Luisa was diagnosed with a ‚major depressive episode' and prescribed an antidepressant. She continued to take it despite side effects (nausea and sleep disturbances), which the paedopsychiatrist considered to be normal, mild and transient, and an antipsychotic was added shortly afterwards. After the second hospitalisation, the paedopsychiatrist also informed the competent Social Work Centre on behalf of the patient, as she felt that the parents had not cooperated sufficiently. The mother complained to me that she had indeed become increasingly critical of the treatment, which had not brought about any improvement and was mainly based on medication, short and too infrequent individual sessions between her daughter and the paedopsychiatrist, and a half-hour session by the paedopsychiatrist with her and her husband. However, the parents eventually lost faith in the psychiatrists when the hospital began to push for Luisa to be placed in a community residential group for adolescents. This plan by the psychiatric ward was obediently followed by a social worker from the Social Work Centre who promised to find a place for a direct transfer from the hospital to such a community as soon as possible. The parents felt cornered and blamed for their daughter's problems. „And they think that everything they do is great! They don't question anything about their part in the failure!" said the mother indignantly.

We immediately established a good rapport with the mother in a conversation that lasted an hour and a half. It was not difficult for me to understand her indignation and her strong opposition to her daughter being placed in a group home. „Luisa has her own home and my husband and I are ready to do everything we can to get out of this crisis. But how can we help when the psychiatrists and social workers have not involved us?" she added, her voice breaking with grief. My intuition told me that working with her could go well and that it was worth responding immediately and offering treatment at our clinic. The mother agreed. As soon as we had finished, I contacted the Paedopsychiatric Unit and the Social Work Centre, given the urgency of the situation. Both the attending psychiatrist and the social worker were pleasant to talk to and very quickly agreed to give me and our team at the clinic six months for combined psychiatric and psychotherapeutic treatment. I asked them to wait for a community placement during this time and promised that if our help did not bear fruit, we would leave the treatment to them again.

Treatment continued according to the biopsychosocial model. Immediately after her discharge from hospital, Luisa began attending regular weekly one-hour meetings with a student of systemic psychotherapy who was working under my supervision (Vajda, 2024). Two or more meetings were needed in a week or so when Luisa was in crisis. She could also contact the psychotherapist by phone or email. We had family therapy sessions at least once a month, which included not only her parents but also her four-year-old brother. There were also sessions with just the parents when necessary. I took over the psychiatric treatment and soon both Luisa and her parents were in favour of gradual reduction of the antipsychotic and antidepressant, so that she was only supported by natural nutritional supplements. We also met the social worker in charge of the case at the Centre for Social Work to further strengthen trust and cooperation. Throughout the treatment, we sent her monthly written reports on positive developments.

Regular supervision meetings with the therapist showed that she and Luisa had developed a safe and trusting relationship. The girl herself expressed that she experienced the therapist as an ally and supporter, and as someone who believed in her and her ability to move forward and overcome challenges. Initially, she agreed to the therapy sessions more because of her parents‘ firm determination, but after three months she declared that she wanted them herself. It was important for her that the therapist, in addition to working on ‚problems‘, also gave space to issues that were important to her at the time (relationships, school, her activities, etc.). The therapist identified many resources in Luisa, ranging from her intelligence and general attitude, her humour, creativity, communication skills, curiosity and persistence, to her wide social network. She liked order and organisation, but was also happy to indulge in occasional „obsessions“ as she called them, i.e. fun short-term activities such as collecting lip balm, counting cats, cooking soup, baking cakes, jumping on the trampoline, ironing, badminton, etc.

With regard to self-harm, they started from a positive point of view, that it was a way of controlling unpleasant feelings of anxiety and that it would simply go away as she found better ways. She said that she had learnt to cut from a classmate and had initially done it out of curiosity. When she found that it reduced her distressing anxiety, she continued. She could not recall any other specific reason for cutting. However, her mother said that she had been greatly influenced at the time by the conflict between her father and her grandfather, to whom Luisa was attached, who had moved into an old people‘s home. Although Luisa did not outwardly show that she was affected, her mother was convinced that she was deeply affected by these events. The mother also felt that it was

significant that the cutting had started at a time of restrictive measures due to the covid epidemic, when Luisa had been in online education for a year. She gradually lost motivation for school, where she had previously been an excellent student. Her school performance dropped from the best to the middle of the class. As a social person, she missed contact with friends and hobbies (horse riding, dancing, going to music school). She spent more and more time on her mobile phone and on social networks, about 4 hours a day and up to 6 hours at weekends. When she returned to school, she was often absent due to mental health problems and school became stressful for her.

In order to manage her anxiety, she also practised various relaxation and mindfulness techniques with her therapist in order to improve her ability to regulate her emotions. Her ‚distress‘, she said, was often related to school (‚when there is too much work, everything piles up‘), but in parallel she talked about tensions at home, especially between her parents (in the course of our treatment, the mother and her children moved away from the father, which she had thought about for a long time and finally did, but which did not have a negative impact on our collaboration, as the father remained highly motivated and constructive; in general, his attitude towards both children was caring). The influence of peer ‚competition‘ was significant, as she followed or was in contact on social networks with other adolescent girls who were also self-harming. She eventually gave up this comparison as it began to seem „pointless“ to her. Her reluctance to stop cutting was that she had to take responsibility for herself. But it helped that she was starting to care, because she had not cared before. At the same time, she was empowered by the fact that she was able to stop hurting herself from time to time, and that the situation at home had stabilised after she moved out, becoming „quiet and comfortable“, as she put it.

The treatment was completed after more than two years, after 42 individual and about 10 family therapy sessions. A few months after the end of the process, she and the therapist met for an evaluation. She said she was doing well. She was looking forward to going on holiday with her parents and her crush, which had already started at the end of treatment, was still in full bloom. She was getting on well with her boyfriend and seemed to have been lucky in her choice, receiving support, understanding, help and friendship from him so that she felt accepted for who she was. And they had fun and laughed a lot, she added. At school, she sometimes slipped up in subjects she did not like, but otherwise she was happy with her academic performance. She was quite understanding of the difficult relationship between her parents, but she also set clearer boundaries for them. This was illustrated by an example where she made it clear to her father why she felt that some of the topics he raised were not appropriate for her as his daughter, but were his responsibility.

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