een initiatief vanuit het Zorgcircuit Psychose Noord-West-Vlaanderen

op weg met Open Dialogue

ruimere introductie en verdere verdieping rond de principes en praktijk van Open Dialogue

19 en 20 oktober 2017
CC De Valkaart, Oostkamp

op weg met Open Dialogue

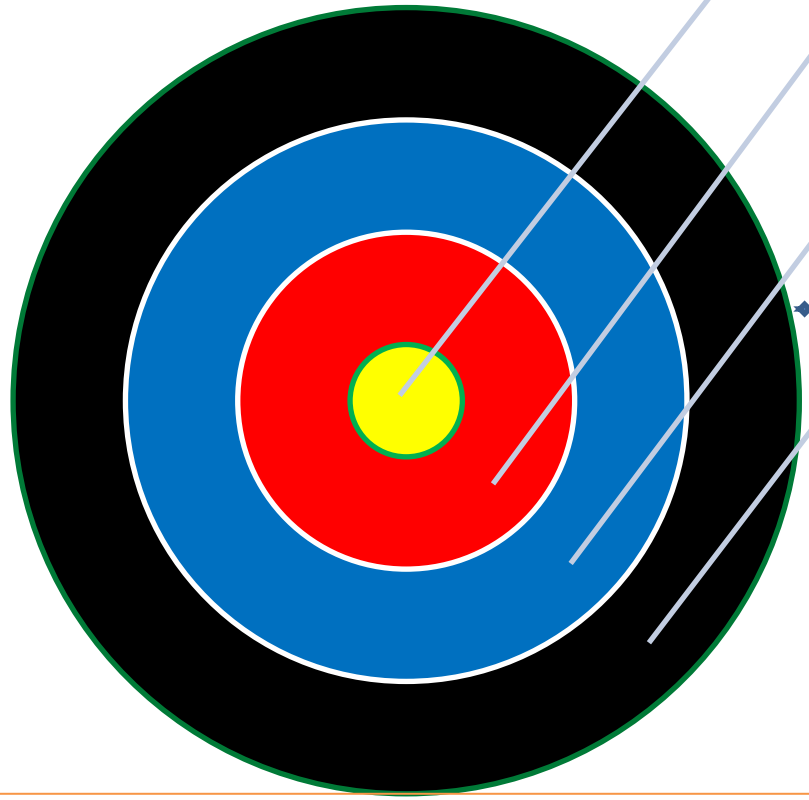
welkom en inleiding

dr. Carmen Leclercq

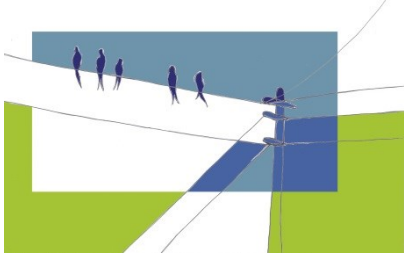
Op weg met Open Dialogue

19 & 20 oktober 2017

Dr. Carmen Leclercq


Patiënt
familie
Netwerk
maatschappij

The times they are a-changing



Come gather ‘round people
Wherever you roam
And admit that the waters
Around you have grown
And accept it that soon
You’ll be drenched to the bone
if your time to you
Is worth savin’
Then you better start swimmin’
Or you’ll sink like a stone
For the times they are a-changin’

Christine Van Damme

Dag Van Wetter

Hilde Maet

Marc Calmeyn

Lies Evens

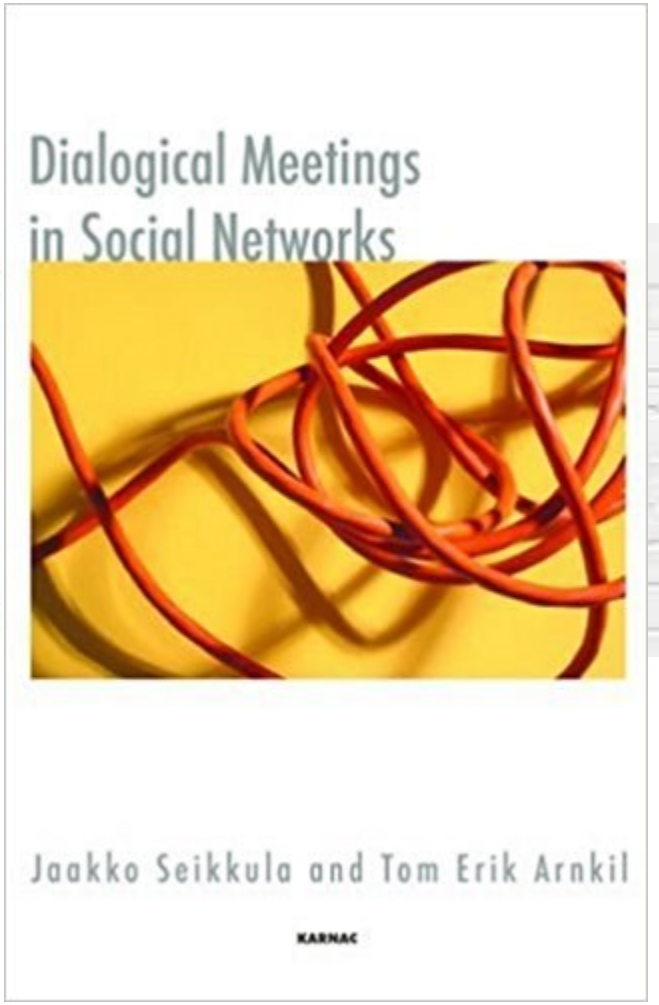
Dominique Degrande

Line Vereecke

De 7 principes van open dialogue

Guiding Principles of the Open Dialogue Approach:

1. IMMEDIATE HELP
2. FAMILY / SOCIAL NETWORK PERSPECTIVE
3. FLEXIBILITY AND MOBILITY
4. RESPONSIBILITY
5. PSYCHOLOGICAL CONTINUITY
6. TOLERANCE OF UNCERTAINTY
7. DIALOGUE (& POLYPHONY)



De 7 principes van Open Dialogue:

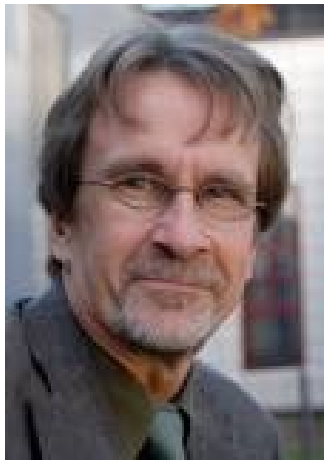
1. Onmiddellijke hulp: binnen 24 uur
2. Perspectief van sociaal netwerk, vanaf de eerste bijeenkomst
3. Flexibiliteit en mobiliteit (tijd, plaats en inhoud naar behoefte)
4. Verantwoordelijkheid, vanaf het eerste contact
5. Psychologische continuïteit (zelfde team, nu en bij terugval)
6. Tolerantie voor onzekerheid/niet-weten:
   geen diagnose stellen maar betekenis op laten komen
7. Dialogisme: het bevorderen van dialoog staat voorop

www.podnederland.nl

Op weg met open dialogue

The soul was treated with certain charms, my dear, these charms were beautiful worlds

PLATO, Charmides



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op weg met Open Dialogue

toelichting programma

prof. dr. Stijn Vanheule

op weg met Open Dialogue

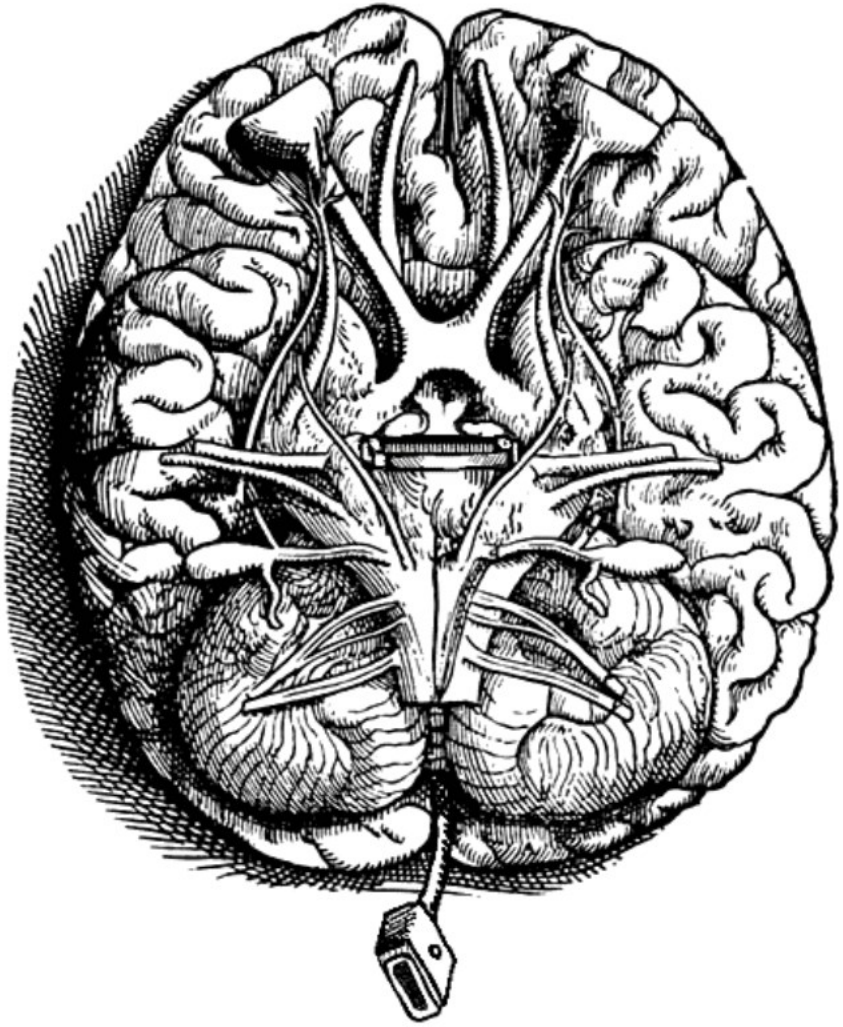
10u00	introductie rond Open Dialogue (deel 1) – prof. dr. Jaakko Seikkula
	syntheses en verder gesprek – prof. dr. Stijn Vanheule
11u15	pauze
11u35	introductie rond Open Dialogue (deel 2) – prof. dr. Jaakko Seikkula
	syntheses en verder gesprek – prof. dr. Stijn Vanheule
12u55	toelichting namiddag – individueel programma volgens inschrijving
13u00	middaglunch
14u00	workshops – verdieping rond Open Dialogue
	1) Jim Wilson over dialogisch werken en meerstemmigheid – blauwe zolder
	2) Nina Saarinen en Wilma Boevink over de meerwaarde van de Open Dialogue principes – bovenzaal
	3) Helle Vase Sørensen en Dorte Elleby over implementatie en samenwerking rond Open Dialogue – podium theaterzaal
16u30	afsluitend netwerken en receptie

prof. dr. Stijn Vanheule

… psychose wel

www.psychosenet.be

prof. dr. Stijn Vanheule



prof. dr. Stijn Vanheule

prof. dr. Stijn Vanheule

Ce que l'on conçoit bien s'énonce clairement,
Et les mots pour le dire arrivent aisément
(Boileau)

prof. dr. Stijn Vanheule

psychose als psychische realiteit

≠ zoeken naar onderliggende essentie

= focus op subjectieve impact

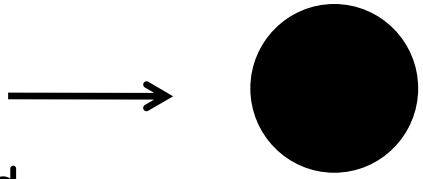
= symptoom als crisis; als antwoord

= zoeken naar een logica

= logica van de ontmoeting

psychotische crisis ← geen spontaan antwoord hebben op uitdagingen

- man / vrouw zijn
- partner zijn
- ouder / kind zijn
- leven versus dood



strategie:

→ Lacan: conversatie

→ Seikkula: dialoog

Jaakko Seikkula:

- Professor Psychotherapie aan de Universiteit van Jyväskylä in Finland.

- Van 1981 tot 1998 hoofd-psycholoog Keropudas Hospital in Tornio, Finland.

Kernideeën *Open Dialogue*

- **Psychotische symptoom = overlevingsstrategie binnen extreme situatie; poging tot communiceren**

- **Open Dialogue:**
  - **Open communiceren binnen context; respect voor alle stemmen**
  - **Patiënt en familie actief betrekken in besprekingen**
  - **Ambulant en snel als het kan**
  - **Continuïteit in de begeleiding**
  - **Gevormde professionals**

op weg met Open Dialogue

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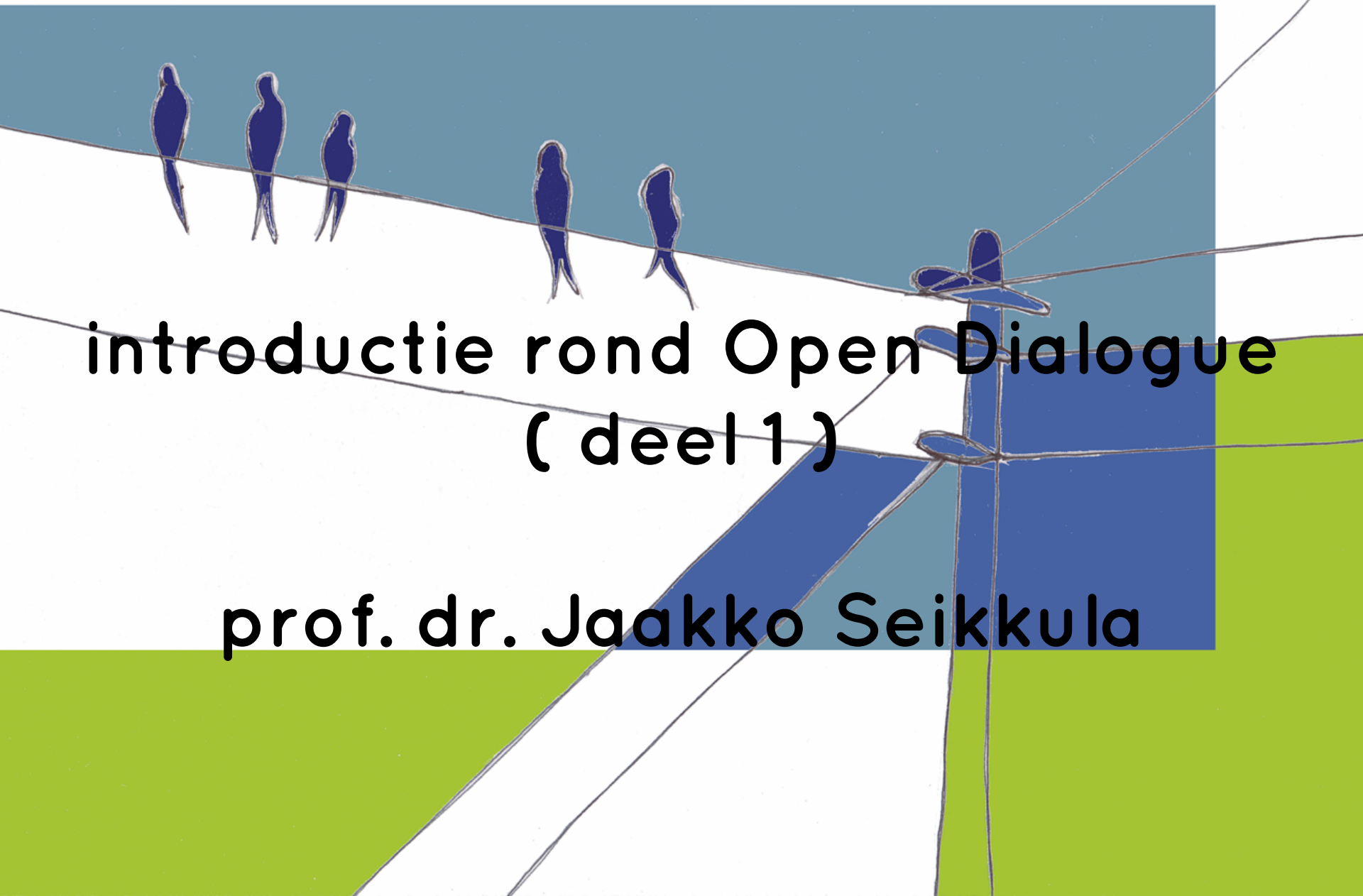
op weg met Open Dialogue



introductie rond Open Dialogue (deel 1)

prof. dr. Jaakko Seikkula

OPEN DIALOGUE in the new era of mental health care

Jaakko Seikkula
jaakko.seikkula@jyu.fi

Seikkula, J. & Arnkil, TE: Open dialogues and anticipations. Respecting Otherness in the present moment. Helsinki: THL
www.thl.fi/bookshop (2014)

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- **Aaltonen, J., Seikkula, J., & Lehtinen, K.** (2011). Comprehensive open-dialogue approach I: Developing a comprehensive culture of need-adapted approach in a psychiatric public health catchment area the Western Lapland Project. *Psychosis*, 3, 179-191
- **Seikkula, J., Alakare, B., & Aaltonen, J.** (2011). The comprehensive open-dialogue approach (II). Long-term stability of acute psychosis outcomes in advanced community care: The Western Lapland Project*. Psychosis, 3,* 192-204. DOI:10.1080/17522439.2011.595819
- **Whitaker, R.** (2010). Anatomy of an epidemic. Magic bullets, psychiatric drugs, and the
- astonishing rise of mental illness in America. New York, NY: Crown.

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- “... authentic human life is the open- ended dialogue. Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. ***In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds.*** He invests his entire self in discourse, and this discourse enters into the dialogic fabric of human life, into the world symposium.” (M. Bakhtin, 1984)

Change in psychiatry: Neuroleptic medication related to brain shrinkage (Andreasen, 2011)

"Longer follow-up correlated with smaller brain tissue volumes and larger cerebrospinal fluid volumes.
Greater intensity of antipsychotic treatment was associated with indicators of generalized and specific brain tissue reduction after controlling for effects of the other 3 predictors. ***More antipsychotic treatment was associated with smaller gray matter volumes***. Progressive decrement in white matter volume was most evident among patients who received more antipsychotic treatment.

Illness severity had relatively modest correlations with tissue volume reduction, and alcohol/illicit drug misuse had no significant associations when effects of the other variables were adjusted."

Beng-Choon Ho,Nancy C. Andreasen, Steven Ziebell,Ronald Pierson,Vincent Magnotta
Long-term Antipsychotic Treatment and Brain Volumes *A Longitudinal Study of First-Episode Schizophrenia* *Arch Gen Psychiatry. 2011;68(2):128-137*

Neuroleptic medication may be related to increased mortality (Joukamaa, 2006; Kiviniemi, 2014; Moilanen, 2016)

- During a 17-year follow-up, 39 of the 99 people with schizophrenia died. Adjusted for age and gender, the relative mortality risk between those with schizophrenia and others was 2.84 (95% CI 2.06-3.90), and was 2.25 (95% CI1.61-3.15) after further adjusting for somatic diseases, bloodpressure, cholesterol, body mass index, smoking, exercise, alcohol intake and education. **The number of neuroleptics used at the time of the baseline survey showed a graded relation to mortality.** Adjusted for age, gender, somatic diseases and other potential risk factors for premature death, the relative risk was 2.50 (95% CI1.46-4.30) per increment of one neuroleptic.
- Joukamaa M, Heliovaara M, Knekt P, Aromaa A, Raitasalo R, Lehtinen V. Schizophrenia, neuroleptic medication and mortality. Br J Psychiatry. 2006 Feb;188:122-7

.

”Talking cure is back”

- Non medication or low dose fep patients had better social outcome in seven years (Wunderink et al., 2013)
- Cognitive therapy effective in psychosis without neuroleptic medication (Morrison et al.,2014)
- ”Talking cure” of psychosis is coming back – 10 approaches, OD one of them (Science, 3/2014)
- RAISE study: Talking cure with the team and the family having low dose of psychosis medication superior to TAU medication practice (American Jo Psych; 10/2015)

”We need to rethink our practices”

- Patrick McGorry, Mario Alvarez-Jimenez, &Eoin Killackey, (2013) AntipsychoticMedication During the Critical Period Following Remission From First-Episode Psychosis Less Is More. JAMA Psychiatry.
- Tom Insel: New medication procedure needed.
- **Antipsychotics: Taking the Long View**
- By Thomas Insel on August 28, 2013
- http://www.nimh.nih.gov/about/director/index.shtml

Robin Murray: Mistakes I Have Made in My Research Career

Schizophrenia Bulletin 21.12.2016

“ In the decades following 1976, I spent more time and energy than I like to recall, trying to find what caused the brain changes in schizophrenia. Sadly, I did not realize that the effects of risk factors such as adverse obstetric events, on brain structure and function, which can be readily seen in nonschizophrenic samples, are obscured in people with established schizophrenia by the effects on antipsychotics and other nonspecific factors.”

Three hypothesis

- ”Psychosis” as a category does not exist
- Psychotic symptoms are not symptoms of an illness

  - strategy for our embodied mind to survive strange experiences
- Longstanding psychotic behaviour is more an outcome of poor treatment in two respect

  - treatment starts all too late

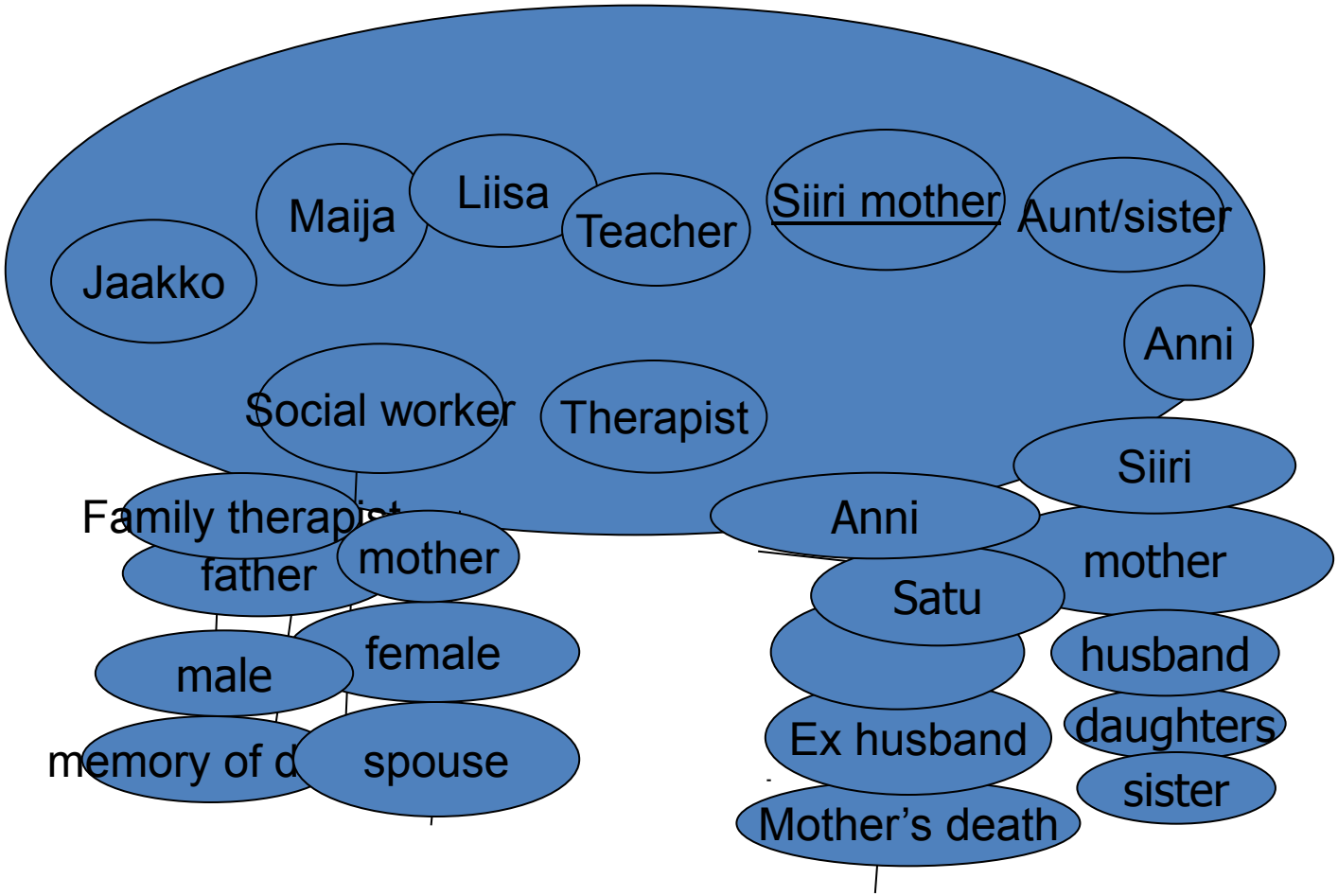
  - non adequate understanding of the problem and human life leads to a wrong treatment response

Psychotic behavior is response

- More usual than we have thought – not only patients - “psychosis belongs to life”
- Hallucinations include real events in one’s life – victim of traumatic incidents – not as reason
- Embodied knowledge – non conscious instead of unconscious – experiences that do not yet have words
- Listen to carefully to understand - guarantee all the voices being heard

Psychosis and embodiment

- Movement – affects – emotions
- In psychosis more essential: psychological as well as communication in the sphare of embodied movements and affects – less words for thoughts related emotions
- Therapist easily living the same type of body affects by sensing something without words – resemplance with the patient's feelings/affects



- ”Vertical polyphony” = inner voices

Origins of open dialogue

- Initiated in Finnish Western Lapland since early 1980's
- Need-Adapted approach – Yrjö Alanen
- Integrating systemic family therapy and psychodynamic psychotherapy
- Treatment meeting 1984

Before Open Dialogue in Western Lapland

- Treatment meetings in the hospital 1984
- Admission meetings in the hospital since 1988
- Need for hospitalization decreased radically – crisis intervention teams and home visits since 1990
- Comprehensive community care since 1990
- Research project 1994 – 1995 (Jukka Aaltonen) Main elements of optimal treatment – Open Dialogue

What is Open Dialogue?

- Guidelines for clinical practice
- Systematic analysis of the own practice.

  In Tornio since 1988: Most scientifically studied psychiatric system?
- Systematic psychotherapy training for the entire staff.

  In Tornio 1986: Highest educational level of the staff?

MAIN PRINCIPLES FOR ORGANIZING OPEN DIALOGUES IN SOCIAL NETWORKS

- IMMEDIATE HELP
- SOCIAL NETWORK PERSPECTIVE
- FLEXIBILITY AND MOBILITY
- RESPONSIBILITY
- PSYCHOLOGICAL CONTINUITY
- TOLERANCE OF UNCERTAINTY
- DIALOGISM

IMMEDIATE HELP

- First meeting in 24 hours
- Crisis service for 24 hours
- All participate from the outset
- Psychotic stories are discussed in open dialogue with everyone present
- The patient reaches something of the ”not-yet-said”

SOCIAL NETWORK PERSPECTIVE

- Those who define the problem should be included into the treatment process
- A joint discussion and decision on who knows about the problem, who could help and who should be invited into the treatment meeting
- Family, relatives, friends, fellow workers and other authorities

FLEXIBILITY AND MOBILITY

- The response is need-adapted to fit the special and changing needs of every patient and their social network
- The place for the meeting is jointly decided
- From institutions to homes, to working places, to schools, to polyclinics etc.

RESPONSIBILITY

- The one who is first contacted is responsible for arranging the first meeting
- The team takes charge of the whole process regardless of the place of the treatment
- All issues are openly discussed between the doctor in charge and the team

PSYCHOLOGICAL CONTINUITY

- An integrated team, including both outpatient and inpatient staff, is formed
- The meetings as often as needed
- The meetings for as long period as needed
- The same team both in the hospital and in the outpatient setting
- In the next crisis the core of the same team
- Not to refer to another place

TOLERANCE OF UNCERTAINTY

- To build up a scene for a safe enough process
- To promote the psychological resources of the patient and those nearest him/her
- To avoid premature decisions and treatment plans
- To define open

DIALOGISM

- The emphasize in generating dialogue - not primarily in promoting change in the patient or in the family
- New words and joint language for the experiences, which do not yet have words or language
- Listen to what the people say not to what they mean

op weg met Open Dialogue

synthese
en verder gesprek

prof. dr. Stijn Vanheule

Synthese Seikkula – Deel 1

- Bakhtin: Het leven is dialogisch van aard; ons hele zijn en lijf is er in betrokken.
- Dialogeren is van levensbelang, zoals ademen.
- Dus: ook dialogeren met mensen in crisis

- Anti-psychotische medicatie heeft niet altijd gunstig effect → opnieuw aandacht voor gesprekstherapie

- Psychotische symptoom = overlevingsstrategie binnen extreme situatie; extreme stress; traumatiserende gebeurtenissen → we moeten er woorden voor vinden; geval per geval

- Psychotische symptomen komen meer voor dan je denkt.

- Vaak veel te laat passende behandeling.

- Basis: behandeling afstemmen op de noden (need-adapted approach; Alanen) + systemische en psychoanalytische ideeën.

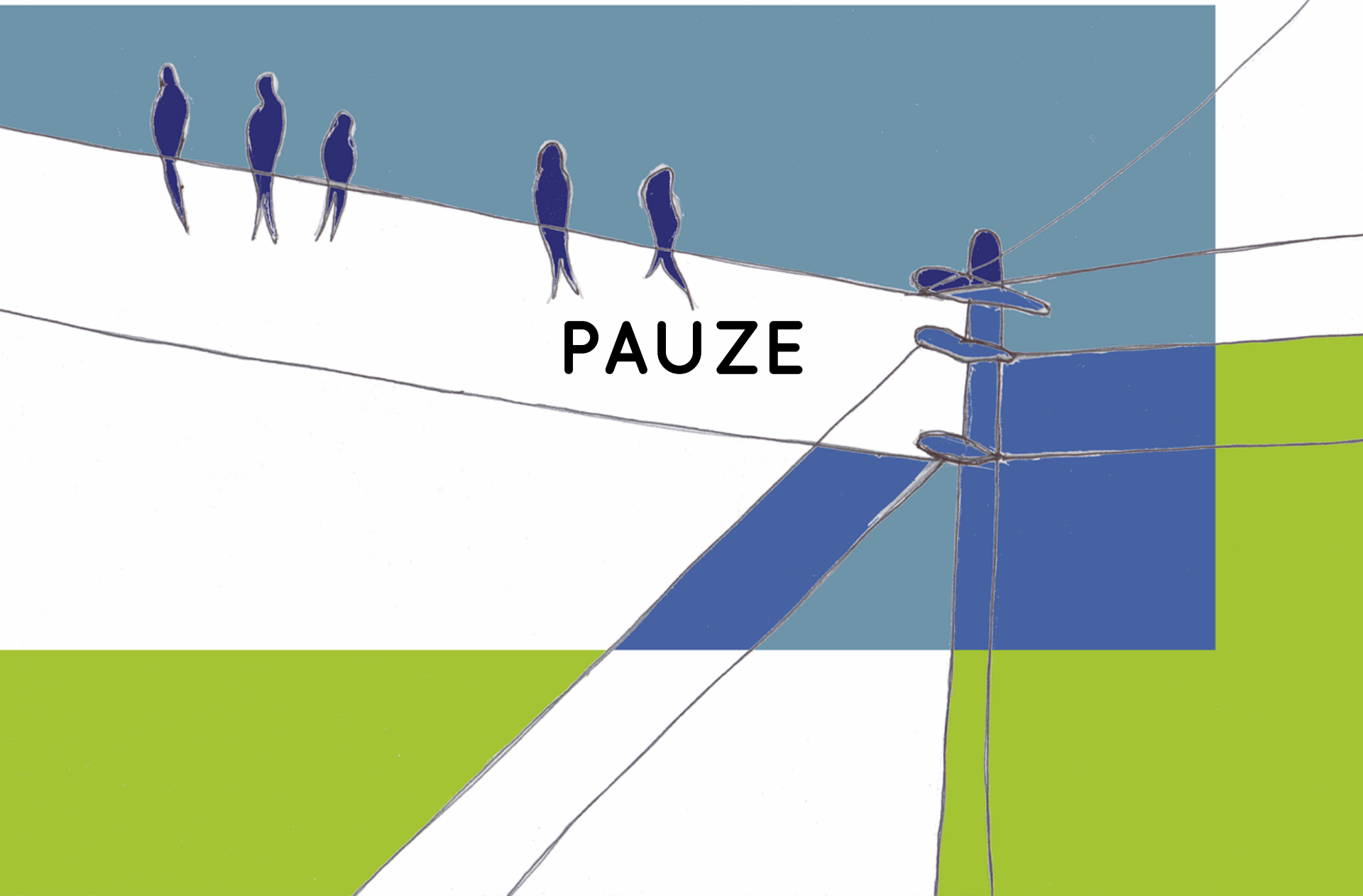
- Open Dialogue:
  - Patiënt en familie actief betrekken in besprekingen → principiële beslissing
  - Niet alle crisissen vereisen residentiële opname

- Cruciaal om het doen werken:
  - Medewerkers continu opleiden → psychotherapie
  - Onderzoek doen naar uw Open Dialogue werk

KERNPRINCIPES

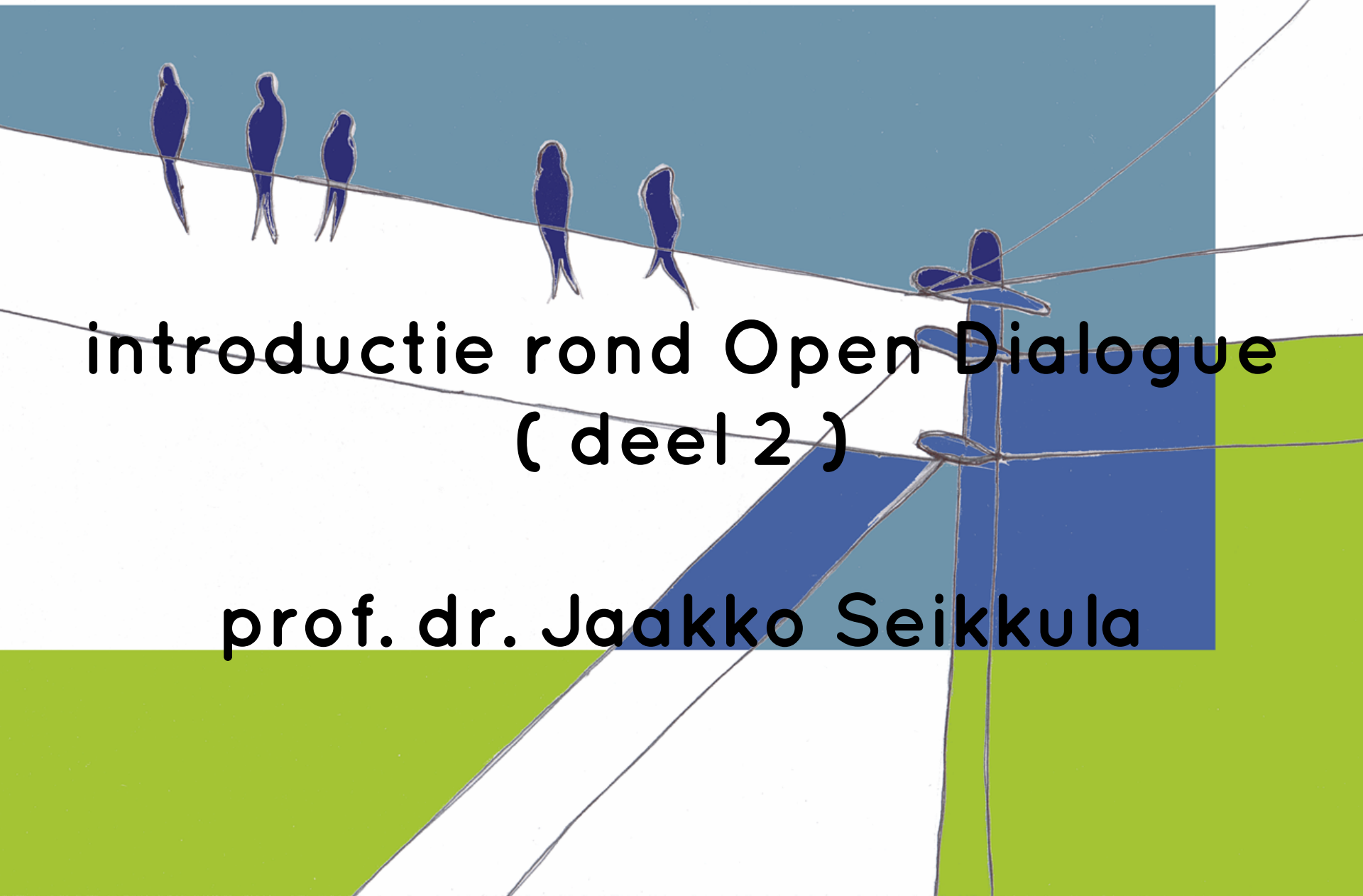
- ONMIDDELLIJKE HULP → binnen de 24u; Crisis = mentale openheid om te spreken over psychotische ervaringen
- SOCIAAL NETWERK PERSPECTIEF
  → naasten betrekken: patiënt niet isoleren van omgeving;
  → samen het pijnlijke bespreken; verschillende stemmen horen
- FLEXIBILITEIT EN MOBILITEIT → geen vast protocol
- VERANTWOORDELIJKHEID → gecontacteerde professional is verantwoordelijk
- PSYCHOLOGISCHE CONTINUÏTEIT → team met residenteel en outreachend personeel volgt hele traject; zoveel en zolang als nodig
- TOLERANTIE VAN ONZEKERHEID → veiligheid opbouwen; (ver)dragen van verschillende perspectieven in familie.
- DIALOGISME

op weg met Open Dialogue



PAUZE

op weg met Open Dialogue



introductie rond Open Dialogue
(deel 2)

prof. dr. Jaakko Seikkula

OPEN DIALOGUE MEETINGS: Everyone participates from the outset

- Everyone participates from the outset in the meeting
- All things associated with analyzing the problems, planning the treatment and decision making are discussed openly and decided while everyone present

Variations: Acute Team in Tromsso

- Dr. Magnus Hald and Annrita Gjertzen
- Acute team in connection with the acute ward
- Good strength (n=15/70 000), work from 8 a.m. to 8 p.m. every day, night duty in the ward
- All contacts to acute psychiatry via the team
- Reflective processes as the form of dialogues – one interviews, the othe one(s) listening and commenting later on
- Two years training for the staff (”Relation and network education”)

Variations: Children and Adolescent Psychiatric Unit in Gällivare, Schweden

- Dr. Eva Kjellberg
- Serves large area with 200 000 inh
- Nearly connected to social care
- After referral always the first meeting together with the family, the referedd authority and relevant others
- Need for further treatment decreased rapidly when the network mobilized
- Reflective processes as the form of dialogue
- Two years training

Variations: Home Treatment Teams in Germany

- Dr. Volkmar Aderhold and Nils Greve
- Ambulatory services for acute patients in the psychiaric units (population can be e.g. 200 000 to 300 000)(N= 22 teams at the moment)
- Insurance driven practice – specific agreement with insurance companies of a project period – evaluation started
- One year training programs

Variations – three US projects

- Umass Medical School: Key elements of Open Dialogue
- New York: Parachut project – 5 teams
- Advocates Framingham Massachusetts
- Vermont state
- 1 to 2 years education programs for clinicians and peers

Peer supported Open Dialogue

1) UK – several Mental Health Trusts

- OD principles including peers as resources
- Foundation training of Open Dialogue – 20 days

2) Open Dialogue certificate three years training (60 ect)

- Including trainers in training
- Peers

Open Dialogue in Italy

- 8 provinces
- 80 professionals training – 16 days + supervision
- Research on the effectiveness and processes

1:GUARANTEEING JOINT HISTORY

- Everyone participates from the outset in the meeting
- All things associated with analyzing the problems, planning the treatment and decision making are discussed openly and decided while everyone present
- Neither themes nor form of dialogue are planned in advance

2: GENERATING NEW WORDS AND LANGUAGE

- The primary aim in the meetings is not an intervention changing the family or the patient
- The aim is to build up a new joint language for those experiences, which do not yet have words

3: STRUCTURE BY THE CONTEXT

- Meeting can be conducted by one therapist or the entire team
- Task for the facilitator(s) is to (1) open the meeting with open ended questions; (2) to guarantee voices becoming heard; (3) to build up a place for among the professionals; (4) to conclude the meeting with definition of the meeting.

4: BECOMING TRANSPARENT

- Professionals discuss openly of their own observations while the network is present
- There is no specific reflective team, but the reflective conversation is taking place by changing positions from interviewing to having a dialogue
- - look at your collegian – not at clients
- - positive, resource orientated comments
- - in form of a questions – “I wonder if …”
- - in the end ask clients comments
- Reflections are for me to understand more – not a therapeutic intervention

5 years follow-up of Open Dialogue in Acute psychosis (Seikkula et al. Psychotherapy Research, March 2006: 16(2),214-228)

- 01.04.1992 – 31.03.1997 in Western Lapland, 72 000 inhabitants
- Starting as a part of a Finnish National Integrated Treatment of Acute Psychosis –project of Need Adapted treatment
- Naturalistic study – not a randomized trial
- Aim 1: To increase treatment outside hospital in home settings
- Aim 2: To increase knowledge of the place of medication – not to start neuroleptic medication in the beginning of treatment but to focus on an active psychosocial treatment
- N = 90 at the outset; n=80 at 2 year; n= 76 at 5 years
- Follow-up interviews as learning forums

Dialogical practice is effective

Open Dialogues in Tornio – 5 years follow-up 1992- 1997 (Seikkula et al., 2006):

- - 35 % used antipsychotic drugs
- - 81 % no remaining psychotic symptoms
- - 81% returned to full employment

COMPARISON OF 5-YEARS FOLLOW-UPS IN WESTERN LAPLAND AND STOCKHOLM

	ODAP Western Lapland 1992-1997 N = 72	Stockholm* 1991-1992 N=71
Diagnosis:		
Schizophrenia	59 %	54 %
Other non-affective psychosis	41 %	46 %
Mean age years		
female	26.5	30
male	27.5	29
Hospitalization days/mean	31	110
Neuroleptic used	33 %	93 %
- ongoing	17 %	75 %
GAF at f-u	66	55
Disability allowance or sick leave	19 %	62 %

- *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.

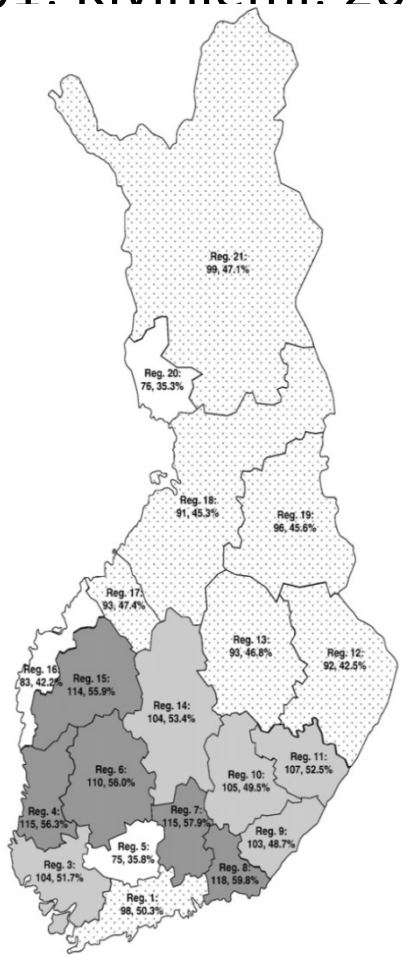
Outcomes stable 2003 – 2005 (Aaltonen et al., 2011 and Seikkula et al, 2011):

- - DUP declined to three weeks
- - about 1/3 used antipsychotic drugs
- - 84 % returned to full employment
- - Few new schizophrenia patients: Annual incidence declined from 33 (1985) to 2-3 /100 000 (2005)

20 year follow-up of Open Dialogue in Western Lapland (Tomi Bergström et al, 2017)

- 65/ 99 were living all their life in Open Dialogue treatment area in Western Lapland
- More sever problems compared to those moved away
- 26% neuroleptic at start; 34% at the follow-up
- Mean 5 years, variation 2 to 8 years

Disability pensions of schizophrenia patients – WL 35 %, (1995 - 2001: Kiviniemi, 2014)



Why the dialogical practice can be effective?

1. Immediate response –taking use of the emotional and affective elements of the crisis
2. Social network included throughout and thus polyphonic in two respect: both horizontal and vertical
3. Focus on dialogue in the meeting: to have all the voices heard and thus working together
4. Avoiding medication that alter central nervous system – antipsychotic medication related to shrinkage of brain (Andreansen et al., 2011) and to decrease of psychological resources (Wunderink, 2013)

"Love is the life force, the soul, the idea. There is no dialogical relation without love, just as there is no love in isolation. Love is dialogic."

(Patterson, D. 1988) Literature and spirit: Essay on Bakhtin and his contemporaries, 142)

op weg met Open Dialogue

synthese
en verder gesprek

prof. dr. Stijn Vanheule

Synthese Seikkula – Deel 2

Wat leert onderzoek naar Open Dialogue?

* (5j, jaren ‘90)

- Significant minder medicatie, minder hospitalisatie, minder in ziekteverzekering

* (3j ‘00)

- Minder schizofrenie (33 → 3 / 100000), minder neuroleptica (1/3), meer aan het werk

*(20j ‘17) ++?

Praktijk van de Open Dialogue bijeenkomst:

- Iedereen doet mee
- Alle discussie over aard problematiek + behandelplanning
- Doel: nieuwe taal vinden; luisteren + vragen stellen ≠ actief willen veranderen

Procesverloop:

- Starten met open vragen ≠ niet uw agenda!: wat is er aan de hand?
- Wie start met spreken brengt belangrijke issues → volgen
- Een plek voor elke stem; ruimte bieden → Ruimte maken voor de interne dialoog
- Professionals bespreken hun inzicht in bijzijn van iedereen (reflectie op verhalen; ideeën behandelstappen) → Transparantie interne dialoog professionals
- Eigen input; formaliteiten → laatste 10 minuten
- Sluiting: nog kwesties?

Casus:

Amerikaanse familie: vader, moeder, zoon B. (8j in psychose; heroïne)

- professionals: Jaakko, Mary
- “*hier zijn we dus*” “*zullen we starten*?”
- B. acuut psychotisch, hele tijd
- “*B.*” aanspreken, mag liggen
- “*waarom we nu hier, wie nam initiatief*?”
- Mensen hun uitspraken teruggeven “*je verwachtte geen antwoord?*” → woordelijk!
- “*kan je er iets meer over zeggen*?”

- B. verlaat ruimte: aanspreken “*wanneer gehoord van het gesprek*?”, oogcontact
- Verhaal volgen, aanvaarden → korte antwoorden toelaten
- “*geen handen schudden*” “*waarom*” “wil geen aanraking”
- “*Hoe gaan we onze tijd gebruiken*?”
- Reflectieve dialoog professionals: “*is het OK dat we even van gedachten wisselen*?” → “*wat me is opgevallen…*”
- Effect: betrokkenheid en participatie

op weg met Open Dialogue

13u00 middaglunch

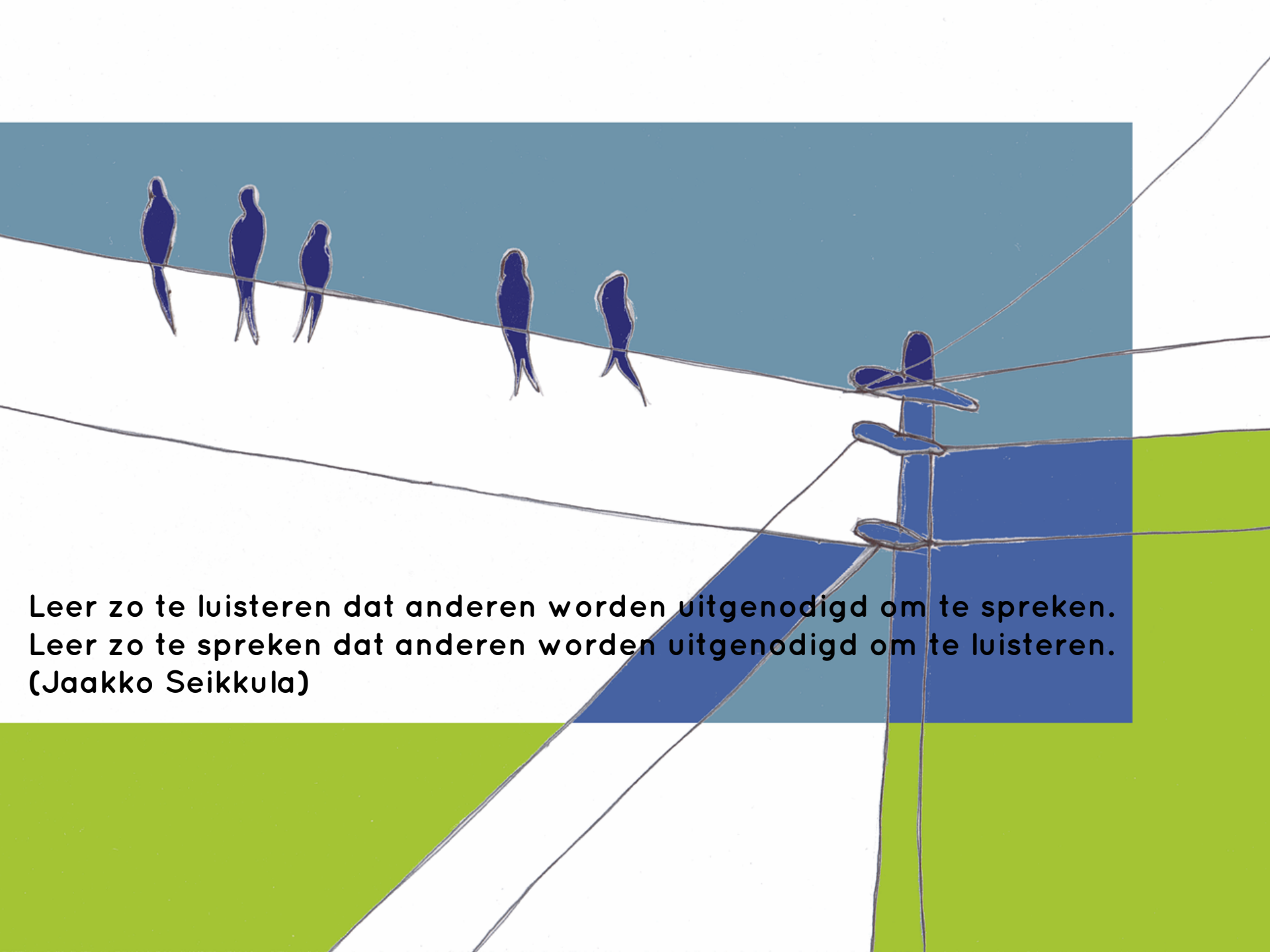
14u00 verdieping rond Open Dialogue
workshops (individueel programma volgens inschrijving)

1) Jim Wilson (blauwe zolder)
over dialogisch werken en meerstemmigheid

2) Nina Saarinen en Wilma Boevink (bovenzaal)
over de meerwaarde van de Open Dialogue principes

3) Helle Vase Sørensen en Dorte Elleby (podium theaterzaal)
over implementatie en samenwerking rond Open Dialogue

16u30 afsluitend netwerken en receptie



Leer zo te luisteren dat anderen worden uitgenodigd om te spreken.
Leer zo te spreken dat anderen worden uitgenodigd om te luisteren.
(Jaakko Seikkula)

zorgcircuit psychose

verbindend spreken