THE OPEN DIALOG BY JAAKKO SEIKKULA (INTERVIEW WITH JAAKKO SEIKKULA)

O DIÁLOGO ABERTO POR JAAKKO SEIKKULA (ENTREVISTA COM JAAKKO SEIKKULA)

Interview held on April 4, 2019 at the JAAKKO SEIKKULA Symposium: Open Dialogue - Finnish experience of psychotic crisis management conducted with the family, in Curitiba-PR.

INTERVIEWERS: What has to happen for the real dialogue to occur between the subject in crisis and their social network/family?

JAAKKO SEIKKULA: Perhaps one of the basic ideas is about how professionals are ready for studying or listening to the family about their experience. You have mentioned some talks with the families in which they are informed about the problems and how to deal with them. There is a big challenge in having a dialogue in that kind of context. Actually, I know that a lot of programs used this psychoeducational approach at the beginning and they also had a change in their way by working in a dialogical direction. For me the piece of advice number one is: whenever we meet families and people in crisis, we should not establish our own agenda for the meeting but we should start to follow their way of facing the problem, by following their thoughts and their stories and also how they describe their situation at the moment. Besides that, we should adapt things that we know as professionals and should also observe the way they talk about their life situation. A very simple rule, for instance, is: do not open the meeting with the family by establishing your own agenda containing the topics that you want to discuss, but rather leave them to the last minutes of the meeting, in case the family wants you to do so. Instead of that, make an open question, for instance, "how would you like to use time?". Then you should follow the family story without any questions about if it is right or wrong. If you do this, you will immediately see the difference, by allowing the family to have more access to its own resources. This is my main interest: how to have discussions with a family in a way that it may have more access to its own psychological resources, even if it is under a very stressful situation.

INTERVIEWERS: What about the team itself? What are the main characteristics that you consider important to this matter?

JAAKKO SEIKKULA: Of course, working as a team is one of the basic ideas. In health care we stress team work, by having multiprofessional teams composed of doctors, psychologists, nurses, and social workers. This usually means that those people get together and discuss about the case that they are dealing with. Team work in Open Dialogue, nevertheless, is quite different, because all the discussions happen in the clients' presence and having this dialogue means that all of us have our own professional background and also a professional degree. However, we should speak as people rather than as professionals, because we cannot have dialogues between professionals, but only between human beings. This is my experience, but it is a very inspiring way that all professional categories should be connected in an open way. Therefore, we no longer need to follow the idea that it is always the doctor who does the interview and the rest of the people stay sitting silently and following him/her. Instead of that we can have a dialogue in a way that it is based on the natural flow of the conversation. Maybe, for instance, the nurse is the most active person, but at the same time everyone knows that doctors still have their own duties to fulfill even if they are not in charge of the interview. Coming back to your specific question, in Open Dialogue we all sit in a circle, because we think that everything that needs to be discussed it is done when everyone is present. It means for the team that we need to discuss all the issues (that we used to discuss behind closed doors) in the presence of the family, for instance "how do we understand the problem?". Perhaps someone has another name to it. Another question could be "what are the tools to solve this problem?". These are very practical issues concerning how to help the family in this process and it is important for us to be open to all the perspectives. When we work in a hospital, for instance, there are situations in which we have to consider compulsory treatment and we have to do that also a kind of open dialogue and decide how to do it. So, the team can have different ideas about if that is the time that we really need a compulsory care or if there would be some other options, even if we know that in the end, it is the doctor in charge who takes the final decision. On the other hand, for the families and for the clients it is always important to realize that there are choices of the people and that we are not sitting in a court where there is only one right decision. In those conversations we are very respectful to each other, of course, and we do not say "you're wrong and you have to do it this way". We could say that "as a doctor, I can understand your situation and I know that there are a lot of risks in it, but I still think that, as I have visited you at home, perhaps there would be some other options. If you decide that we need to have compulsory actions now perhaps we can get together tomorrow and

see how the situation is". Families like those conversations, according to what they have said. They always say "yes, it was good to have some information about the problem", but they also say that it was much more important to hear how professionals as people speak about their problem. Then concerning the discussion of the professional, there is also a second element, because by being involved with people in crisis, we start to have many impressions, thoughts, and feelings about it. Those are not so concrete considerations about what we have to do in the treatment, but rather a kind of reflections about our feelings, by being involved with the life of a family. This is what we use to call reflective conversations. It is worth pointing out that we, as professionals, do it in a way in order to give the family a possibility to sit in silence and to listen to what we think about the situation. In those conversations we are keen that we have to speak to the family in a quite respectful way. I express myself like "I've got an impression that it could be the case that...". All the time we would really like to have a different perspective about the case and then we always ask the family if it has some comments about it. It is interesting what it says about it. We have had a research project called "Relational Mind" in which we measured the reaction of the autonomic nervous system of the therapists and clients (a couple). We also measured the heart rate and the heart rate variability and we came to a conclusion about the stress experience: usually when professionals discussed a subject to each other it was more stressful to the couple, fact that emphasizes the importance of being quite respectful and not at all criticizing or making negative comments about the situation. At the same time, of course, it is worth realizing that there is nothing wrong with stress, because, in fact, we need it in order to put ourselves in a certain situation in which we become rather curious and listen to the people. On the other hand, we have to avoid too stressful and strange situations, because then families start to defend themselves and they don't listen to us.

INTERVIEWERS: In your articles and texts it is pointed out, as practice, the dialogue between the team during the meetings. Does the dialogue between professionals happen only during sessions or are there any supervision meetings as well?

JAAKKO SEIKKULA: In the very beginning, when we adopted the idea of Open Dialogue meetings, in the early 80's, in order to make it possible to follow the new ideas of treatment, we had two kinds of rules of thumb that we followed as slogans or pieces of advice: the first one was that it is allowed to speak about the patient and take decisions about the families, if only both the patient and the family are present. When we followed these rules, we were

also quite rigid in the beginning, but nowadays we have realized that when we are in a dialogue, the dialogue does not stop when the meeting stops. Therefore, from a good dialogue we actually go on having ideas, and it is always positive to exchange some words with our team members about our feelings from the meeting up to the present moment. However, it is worth pointing out that we should not go on in a conversation in order to take some decisions or some specific plans on how to make a future intervention, but we should wait for the next meeting to happen. Perhaps in the next meeting, we could say something that had come up to our minds about the issues that we had discussed before. Therefore, in addition to that, there are also a lot of issues in our practice that need to have a supervision. Maybe one of the most basic forms is to have a supervision for the teams and in this supervision we could focus on our own experience which is no longer as it used to be (when we discussed about the family and the right solution), but we could rather speak about ourselves and our feelings. If I'm invited to be the supervisor, for instance, I would usually make this question: "how does this feel to you?". Besides that, it is also advisable to speak about our unpleasant feelings and about a judgement we may have which is not sensible to speak openly with the family. In those conversations, we could also ask if the family were there and were listening to our conversation, what it would have said. In Finland, at the moment, I work in a training institute that has had a lot of trainings in this dialogical supervision, by applying it also in many fields, such as in business, for instance. The main idea of these trainings is to focus on ourselves in relation with others, rather than focusing on others in relation with us.

INTERVIEWERS: Research in Open Dialogue indicates a high degree of efficiency, by helping people to return to their lives, but in a few cases, this is not possible. Could you tell us a case from which you did not get the result you had expected?

JAAKKO SEIKKULA: Yes, of course. Failing in the way to helping is part of the practice all the time. I can tell you a very dramatic story: there was this young lady who went with her parents to the crisis clinic that we had at the hospital. They said that she had moved from Sweden to Lapland (they were Finnish in origin) and that they had had some problems after a visit to a doctor in Stockholm, where she had had an operation (lipoaspiration). In the first meeting, however, she was very coherent, saying that she did not want any therapy and her parents said that "if she does not want it, let it be like that". However, two months later, she went back to the hospital in a very bad situation: she had stopped

speaking, seemed to be quite psychotic, and we started to have an active treatment. In fact, she was also part of the study I had commented earlier: in order to have less anxiety, she was prescribed anxiolytics and she had psychotherapy as well. We met the family and, step by step, things seemed to start to proceed well. That continued for five months more, when she was discharged from the hospital. Then something happened and, actually, we never knew what had happened. She became worse after half a year of treatment, and that was the time when a new neuroleptic medication for psychosis was also studied. We continued with the therapy, the family meetings, and she started to proceed a bit, but again for some reason, she stopped the medication. This happened when she was hospitalized for urinary tract infection and then nothing seemed to help her: she was living in a very specific situation concerning language, for instance, she was speaking and suddenly the sentence broke up, as if falling down into a very deep hole. Her parents explained, actually, what had happened: in her childhood, they moved to Stockholm, when she was three or four years-old, in the process of learning her first language, Finnish. After many years in Stockholm, she refused to speak at school. Swedish is a very different language compared to Finnish, but she managed to learn it and, in fact, she graduated from high school quite well. However, that was really a failure in many ways, because we did not manage to help them. We went on with the family meetings all the time, and they were very pleased for having those meetings, even though a significant progress had not happened in her life. In the follow-ups - two years, five years - we made a lot of questions about what the family thought about the situation. The parents said that they felt good about it and that we were there to help them, even though their daughter's life was not fairly good. On the other hand, they said that they would definitely like her daughter to be better, but if it was better for her to live with them, they agreed with that.

INTERVIEWERS: Involving the family, or in some cases the person in crisis, in the treatment, is a great challenge for us. What could you say about what can be done to facilitate this process? What can be done when the person in crisis or the social network/the family does not want to participate in the process?

JAAKKO SEIKKULA: One idea of the Open Dialogue is always to respond to the call for help. Whoever makes contact is always responded. If it is a neighbour who makes complaints about another neighbour's life, he/she is responded, and we also have a meeting with

most of them. In most of the crises, the contact is usually made by the mother or father and not by the key person in crisis. And, of course, optimally, in our system, when there is a call, the team goes home even if we know that the people in crisis do not want it. Then we have a dialogue with the parents, or perhaps we may call and knock at the door of someone who has isolated themselves by saying that "your parents invited us to come here and we would really like it if you could also be there; if not, we will have a discussion with your parents, and it is ok if you listen to it". That is the way to do it because we always discuss with the people who want to discuss too. Of course, there are also some situations in which that is not helpful enough or it may even turn the crisis worse. Then some compulsory actions are needed in the end, but they just happen as a part of the process. Meanwhile, there may also be situations in which, for instance, when someone is hospitalized, and we propose to have a meeting with the family, the person says "no, I don't want to speak with them"; at the same time, the mother is continuously calling the doctor and is very anxious about the patient. Then both the mother and the family are invited to the meeting, and we say again to the patient that "your mother really needs to have discussions and we invited her and your family to a meeting, but you can choose if you will be there or not". I know that there is a lot of criticism and discussion against this attitude, because some people have an idea based on confidentiality and think that, by having a meeting with the family and without the patient, is not possible. However, for the Open Dialogue, practicing this is really one of the key elements: we should always work with the family and the social network, because they are really resources for the future to be lighted, as well. In addition to that, in the meetings, very concretely, we also have the voice of the one who is not there, and a very useful question is "if he/she were here with us now, what would he/she have said about the issues that we have discussed?".

INTERVIEWERS: The Open Dialogue proposal is present in several countries today, and I think that adaptations are necessary in relation to the initial proposal of Lapland. How do you see Open Dialogue being used in different cultures?

JAAKKO SEIKKULA: Yes, it is really the case as I have said. Now we have programs of education (Open Dialogue) in 18 different countries, and in some countries, we also have many different projects, not only one. There is a great variation among the countries concerning how the health system is organized. I do not know how it is organized in Brazil. Do you have a kind of insurance-based system or a state-based system of care?

MARIANA: The state has a program of free healthcare, which is universal, but we also have private health insurance, besides the basic public health.

JAAKKO SEIKKULA: I see. In many situations, it is in a way easier to organize, for instance, new teams, or to start to work openly introducing the services to other services. There are some countries which are based on these insurances, for instance, the United States and Germany. Then you need to talk to the insurance company before the treatment starts, which is not totally aligned with Open Dialogue ideas, because we really want to have all the conversations from the very beginning as meaningful for the therapeutic context. However, in some places they have managed to do that. In my experience, it is a bit surprising to me. This seems to be the biggest cultural difference in respect of Open Dialogue. Due to my work, I have a lot of training situation seminars, and I have been involved in family meetings in many different cultures. These cultural differences, however, do not seem to be so much present in family meetings, because, in fact, they are the very same: a meeting in China, where they only have one child and this child has become psychotic, is certainly different from a meeting in Latin America, where the family includes all the aunts, cousins, and grandparents. As for the content of the dialogue, however, is quite similar. It really seems to be possible, and this is for me a kind of repetition of the idea that the dialogue is all over, like breathing, and it is not a cultural question.

INTERVIEWERS: What do you have to say to professionals who work with people with severe mental disorders in a system still very inflexible regarding the forms of treatment?

JAAKKO SEIKKULA: What should I say? Be flexible! I surely know that this is one part of the challenge in our training: how to learn to have a dialogue with a very monological system around us. The most difficult issue is not the families, but the other professionals. Another issue is to learn how to have an open curiosity with my colleagues who have a belief that there is only one truth to be followed. I have a personal rule in those situations: I have to be careful about how to speak about the problems, when I participate in discussions of some crises with other professionals. I do not use attributes to say that something is a question of the person in crisis, but I speak about the possible emotions that the family could have felt in such situations. I talk about doings, for instance, when a son has done something that seems to be quite stupid, I say "I was wondering what was in his mind at that moment". I do not mean this is manipulation or a kind of attribute of his. This is certainly a very small part of the conversation, but it is a very helpful rule to myself.

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