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Contribution to the discussion about *Open Dialogue*

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Among the many considerations that have been put forward on the method described in the article on *Open Dialogue*, I would like to share with the readers of this journal my thoughts regarding the focus on treatment and the crisis of our healthcare services. As a healthcare professional with thirty years of experience in public psychiatric services I have witnessed a gradual and constant 'impoverishment' of the treatment system. This has produced a progressively bigger divide between the premises that should guide treatment according to the principle of psychiatric reform and what actually happens in daily operations. The push to treat a person in his/her environment and therefore to treat the network of relations that this person is surrounded by, has run aground in a system of disconnected outpatient services that mainly work on emergency care. Generating a shared way of thinking on a 'case' (a term that is considered incorrect in Franco Basaglia's view), often becomes an operation that happens 'casually' based on favourable circumstances determined by: the availability of healthcare professionals, their workload in any given moment, and the mental and psychological energy present in their psychic fuel tanks.

Within healthcare services, as I have known them and as I experience them daily, there is no longer one treatment method, but a juxtaposition of outpatient interventions that at times have good results, that in turn do not take root or become part of the system. I would like to underscore all this because the method that is proposed in *Open Dialogue* is an 'archaeological' method that is rooted not in the reality of Finland but in the North-Eastern area of Italy from Gorizia to Trieste. If I had read the article[1] on *Open Dialogue* twenty or thirty years ago, I would have asked myself: 'Where is the novelty in this

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[1]Although *Open Dialogue* is a Finnish model devised in the 1980s, it is in fact rooted in an older way of thinking: that of Franco Basaglia, an Italian psychiatry reformer, who worked in North-Eastern Italy and who abolished mental hospitals in Italy.

method?'. Psychiatric reform at the time unmasked the oppressive forms of institutions (disguised as treatment systems) and described the incapacity of these in 'tolerating uncertainty' and establishing an 'Open Dialogue' to make sense of suffering, which could bring about the creation of self-referential and oppressive treatment structures for patients and also for their families and healthcare providers. The naming of the Italian Healthcare System as an '*Azienda*' (a business firm) and not of a '*Comunità*' (community) brought about certain decisions that ended up modelling the services offered on a 'cost-benefit' basis and on an economic level. One of the results of this was that 'If we examine the amount of activity, in terms of services offered, we observe that of the around 11 million services offered per year, only 6.5% are psychological/psychotherapeutic activities. This confirms the fact that the system is based on a biomedical model, with service provision taking on features of a reparative intervention, as there is no time, praxis or ability to confront the complexity of the crisis in an adequate way.' ('Figli di una politica minore'. Online magazine: Dromo).

My conclusion is that treatment services are 'afflicted'. In trying to answer to suffering without adequate equipment or resources they became saturated with the suffering that they were trying to cure, without being able to elaborate it. The result of all this is that the institution and its operators organize their work to defend themselves from both their suffering and that of others, rather than facing it clinically and productively. The other evidence that allows me to define the services as 'afflicted', comes from the fact that operators who work in this system 'suffer' and their suffering is continuously increasing as they try to do their job.

The proposal to re-discover and re-use *Open Dialogue*, which was a piece of our psychiatric community's DNA, is an opportunity to go back to our roots. Here *Open Dialogue* is interpreted not as a structured setting but as a 'variable structure and procedure' based on the internal emotional set up of healthcare professionals and the institution they work for.

Psychiatric services in the golden age of psychiatric reform did not need an '*Open Dialogue*' model. All operations were characterized as *Open Dialogue* and the tracks that resulted from this, precisely retraced the seven points of Seikkula's article. These were not only applied to psychotic crises but to any type of intervention conducted with the awareness that if healthcare professionals did not treat the person together with their context (within which there are also healthcare providers) the result would be a chronic cycle of suffering.

'Therapeutic principles' which are intrinsic to *Open Dialogue* are traceable and superimposable to the ethnopsychiatry method proposed by Tobie Nathan in Paris, where psychiatric consultations were organized by following the cultural matrices of the person. Thus, consultations were open to the person's 'village' and his/her system of beliefs regarding illness and its

meanings. Consultations were open to all the patient's relatives and to healthcare providers involved. In Italy, there is the example of the Social Medicine Centre in Foggia, curated by Mariano Loiacono, who developed the '*Metodo alla Salute*' (MaS method or Heath method). This is a treatment method based on community and family that is 'horizontal', using innovative and completely anti-institutional contents, and for this reason is probably completely unacknowledged and insufficiently valued.

In Mariano Loiacono's method the intervention of psychotic crises calls for the 'hospitalization' of all the relatives involved in the person's life in a specific structure created for them and where for the entire day the delineated *Open Dialogue* aspects become 'a live phenomenon' in interactions and in the dynamics that the centre proposes.

The *Open Dialogue* method proposed by Seikkula has the advantage of reconnecting us to our treatment roots of psychiatric reform, without producing institutional reorganizations that would not be sustainable and would thus be rejected. Instead of having a team meeting to discuss a 'case', the meeting is carried out with the family and the user of the service. In this meeting everyone together tries to repair the fragmentation caused by the psychic disorder. There is a constant tuning into and re-tuning between the different people involved in the treatment system, a process that can integrate multiple dimensions, devices, and equipment, but it must find a 'control room' where the subjectivity of every person becomes the main resource in the treatment process. We need operations that allow for 'subjectivities' to be recognised in their own suffering and in the resources that are presented to respond to this suffering. This recognition can come about only within a relationship, and relationships exist only if there is *Open Dialogue*.

In my experience, the possibility of working to recreate *Open Dialogue* in a treatment system has immediate beneficial benefits on the treating team. The sense of impotence and solitude in confronting a difficult case disappears, fragmentation is reduced, and the sense of coherence and emotional competence of the system increases, so too does the basic function of 'containment' of psychic agencies. The sense of trust in healthcare providers increases and there is an implementation in the taking charge of emotions and affects in the situation. There is also more exchange and communication between healthcare providers, even beyond the agreed upon meetings.

It would be interesting to compare indices tied to workplace wellbeing between healthcare providers that apply the *Open Dialogue* method directly or indirectly with those that are 'obligated' to use '*closed dialogue'*. The main strength of the method proposed in *Open Dialogue* is the possibility of it being applied without having to reorganize the service in an institutional sense, which would provoke various types of 'rejection'. It is sufficient that the local psychiatric team composed of a psychiatrist, psychologist,

educator, nurse, and social worker decide to work together on a few cases with the proposed method and the aforementioned effects will be immediately obvious and also the clinical results will be positive if the process is maintained in the long-term. Regarding the training, this is a 'critical' aspect. I believe that all those that have been trained in the Basaglia's method do not need specific training, as the modalities and internal devises should be consolidated (this does not mean that it is not necessary to ask for advice, undergo supervision, carry out research in more detail, *etc*.). This is different for the new generations of healthcare providers who did not train in a psychiatric reform context but rather in its regression. They should be offered the opportunity to apply and train using the *Open Dialogue* method and it is an excellent opportunity to retrieve a treatment framework and values that are essential in a public health service.

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