How Can Open Dialogue Change Our Understanding of the Behavior of People Experiencing Psychosis?

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ABSTRACT

The Japanese psychiatric system has had a tendency to institutionalize attaching too much emphasis on the medical model and avoiding uncertainty. The authors have encountered and learned from Open Dialogue practice. In 2019 a dialogical practice unit was formed. The authors held a series of meetings to listen to the voices of those involved and shared the decision-making process with clients and network members. The collaborative process between clients and network members who had been diagnosed with serious mental illness resulted in increased understanding as all voices were shared. In addition, the process increased tolerance for uncertainty and dissolved social alienation, and symptoms were significantly reduced. As a result, 15 out of 35 clients were able to transition to the community within three years. Building on the foundation of horizontal relationships with clients and network members, shared meanings and emotions contributed to this process.

KEYWORDS
Open dialogue, Metaphorical thinking, Psychosis, Meaning-Making, Implementation

INTRODUCTION

There are more psychiatric beds and patients in long-term hospitalizations in Japan than in any other country. Human rights and ethical reforms are yet to progress, and concerns are growing about involuntary treatment in acute care settings. In 1900, a law was passed in Japan allowing psychotic patients to be confined to their homes under certain conditions. Although home confinement was outlawed in 1950, many private mental hospitals were subsequently built, and many patients were forcibly confined. This situation, which can be described as alienation from society, has continued to the present day. The Ministry of Health, Labor, and Welfare in Japan has recommended discharge and community support, but it has not progressed sufficiently.

Treatment as usual as applied in Japan involves power structures within the wards and treatment in closed wards, and power-based methodologies, such as drug sedation, are central to the practice. The social norms and systemic conveniences of the therapist and the logic of protection and control often shape the rules of group living while the rights of patients are less important. Hospitalization is often prolonged or repeated. For those who have been hospitalized for many years, the psychological and social barriers to returning to the community are often high. Moreover, patient-family relationships also tend to be tenuous.

As biological psychiatry has become increasingly valued, the medical model has taken over the treatment of mental health issues. Attention has been focused more on the symptoms than on the patients themselves; medication as a linear problem-solving approach to symptoms has become mainstream. The therapist is primarily an observer from the outside of the problem, and the main focus is on the “I–it” relationship. The opinion of the client regarding the problem is not valued and may not be present in the decision-making process. Clients in situations of involuntary hospitalization or long-term hospitalization are often not invited to participate in the decision-making process.

A closed treatment environment may have contributed to the background of long-term hospitalization and the high likelihood of client rights being violated. However, we have been making efforts to change this situation. In 2009 we established a home nursing station and an outreach project and invited clients to case conferences. During these years, there have been many discussions with administrators and staff members. We have focused on community life, support for daily living, and the needs of the clients.

Regarding a problem-solving strategy, implementing open dialogue (OD), a person-centered, democratic, interactive, process-oriented, and non-pathological approach, seemed appropriate. We introduced dialogue-oriented treatment meetings in 2017 at a private psychiatric hospital in Japan. We launched a dialogical practice team with more than 20 staff members, and repeated treatment meetings have been held.

It would be significant for the unknown to be resolved and for confusion to be eliminated through meaning-making while enduring uncertainty in a secure setting (Seikkula & Arnkil 2014). However, repeated meetings without a meaning-making process may not resolve the confusion sufficiently. What is needed here may be a process that deepens our understanding of the meaning of all attendees. Lovecraft (1927/2013) suggested that humankind's oldest and strongest emotion is fear, and the oldest and strongest fear is the fear of the unknown. Fear of the unknown appears to disrupt relationships that emerge in psychotic crises; disruptions can arise between the client and network members, the client and therapist, or within the client. Therapists might feel unsure about the language and behavior of people diagnosed with psychosis, particularly during a crisis. The National Institute of Mental Health's public document "Understanding Psychosis" also states that people with psychosis can be disruptive, behave unpredictably, and become threatening or violent.

People experiencing psychosis may have fears or intense anxieties about severe trauma or overwhelming experiences, and there may be confusion in the relationship. However, this is by no means valid only for clients but also for our team members. In other words, in the context of conventional psychiatry, people involved in treatment can become fearful, confused, and violent because they feel "unknown and incomprehensible."

This study examines the process of meaning-making during crises related to psychosis. We analyze how OD can change our understanding of the behavior of people with psychotic experiences. Moreover, we reviewed the process of shifting from treatment as usual to dialogical practice and what changes have been made.

PARTICIPANTS AND METHODS

Participants

Participants were clients with long-term hospitalization status.

Action Research

In September 2019, we organized a dialogical practice team with clients in long-term hospitalization situations. The team members included nurses (> 10), care workers (> 4), psychologists (> 1), social workers (> 4), psychiatrists (> 2), and occupational therapists (> 1). The team included therapists (more than 2) who had completed fundamental OD training in Japan. The ethics committee of the hospital approved the research plan. Since the team's inception, author MJ has been involved as an organizer and therapist psychiatrist and YK as a therapist and mental health worker. Both groups conducted participant observations. We conducted action research to address concerns regarding the transition to the community. Action research is a collective, self-reflective inquiry conducted by researchers to understand and improve the practices in which they participate and the situations in which they find themselves.

Interview

We conducted an unstructured interview with a client and network member who participated in treatment meetings with the Dialogical Practice Team. Two of the authors conducted the interviews that lasted for 70 minutes. Verbatim transcripts were prepared by YK and checked for accuracy by MJ.

RESULTS

At the time of establishment of the ward, there were 35 clients. The clients' average age was 61.8 years (18 women and 17 men), with an average length of stay of 9.4 years.

We made an initial arrangement with the clients so that we could make decisions about them at meetings where they were present. We aimed to gradually foster a psychotherapeutic attitude in the ward. We held regular treatment meetings (usually once every two weeks) with each client and their network members. In addition to individual meetings, we held weekly unit-wide group meetings. Clients, network members, and team members gathered at the meetings to have various conversations. Clients and network members talked about what had happened decades ago, often with strong emotions. It was often difficult to comprehend what was being said by the client at once, but sometimes the network members knew the meaning of what was not understood by the treatment team. As meetings continued, they gradually shared their feelings, and sometimes the relationship was restored. For the team members, listening to the client's voice helped them to understand the client's feelings.

Many clients wanted to leave the hospital. In particular, quite a few clients desired to return home. We tried to create opportunities for outings and for clients to stay at their homes. Often, we went out together with clients, visited their homes, and sometimes stayed overnight with them at their homes. Outside the ward, clients were more active, and we learned how important social connections and hope are in a person's life. In one-on-one support, there were few opportunities for clients hospitalized for a long time to try something for the first time. But in a setting where everyone involved was together, it was easier to create momentum to take on challenges despite the uncertainty. Clients who do not usually talk much sometimes become animated at meetings and outings. All team members learned that what experts consider symptoms are never fixed and change with the situation and the occasion. Through repeated meetings, an "I - you" relationship, which could be called the foundation of dialogism, was fostered. Outside the team, we continuously tried to develop a service system during the same period, with network meetings in the outpatient, outreach, and acute care wards. The knowledge gained in these situations was fed into the team's activities.

Challenge for Team Practice

Team members communicated more closely with each other than before. Despite various value clashes, the team gradually became more flexible and mobile by working together.

Soon after the team was established, therapists from the Keropudas Hospital conducted a workshop. It was an opportunity to receive supervision for the meetings we usually conducted and to share with the whole team how to be dialogical. Many other guests visited our hospital, and we held many events. Simultaneously, we realized that our team members gained many insights by inviting visitors to the hospital. These factors shook up the unique power structure of the old psychiatric hospital and made it more open.

The meetings proceed so that everyone who attends can talk about what they want. The emphasis is not necessarily on conversation alone, but on the needs of the client and network members in the space, including taking a walk and cooking together. Reflection is incorporated, and spaces for vertical dialogue are valued. There is also a conference function in which decisions are made democratically on what needs to be done.

The Process of Meaning-Making around Psychosis

We have always emphasized emotions and have tried to create a space where dialogue could occur. However, in psychosis situations, conversations often run parallel and stacked. Although we can guess the meaning of some conversations, this difficulty remains. The remaining uncertainty inevitably made it difficult for authors as therapists to deal with emotions in the "here and now." Therefore, we conducted a theoretical study of OD, and the following made a strong impression on us in our practice.

Seikkula (2019) explains that "psychosis is a reaction to extreme stress and that dialogue is its cure." Karon (2003), who has practiced psychoanalytic therapy with people with psychosis, explains that psychosis is a challenging experience. However, it can be clarified with patience, tolerance, a desire to understand the person in distress, and willingness to take the client's spoken thoughts seriously. Similarly, The British Psychological Society states that psychosis is not distinct from other emotions or thoughts but is understandable and treatable in the same way as anxiety (Cooke 2017).

Furthermore, the relationship between words, feelings, and metaphors is important for understanding clients. Metaphors allow people to use what they know about their direct physical and social experiences to understand more abstract experiences (Lakoff & Johnson 2008). Deamer and Wilkinson (2021) argue that a person with an idea called a delusion may encounter a strong emotion or experience that they do not usually meet and understand it in a metaphorical internal language. Then, through internal dialogue within themselves over time, the internal language may be understood literally, and the belief may become self-attributing (Deamer & Wilkinson 2021). These theories were very useful in actually listening to the client's voice. We used to find clients' words incomprehensible, but by focusing on the emotions behind the words we were able to have more emotional interactions with them.

Effectiveness analysis

As of October 2022, 15 clients (42.9%) had transitioned to the community (two of them were temporarily hospitalized at confirmation). For many clients who continued to be hospitalized, specific community transition plans were shared among the client, network members, and team members which were not in prospect at the time of the team's inception. During the meeting, the need for medication was also revisited. The average usage of neuroleptics (chlorpromazine equivalent) decreased from 954.8±712.4 mg/day (September 2019) to 621.7±397.8 mg/day (October 2022).

Interview

The interview was conducted with Tomoko (pseudonym) and her husband Takashi (pseudonym). Tomoko had been in the hospital for more than five years. Her treatment team was formed at the inception of the unit. The team consisted of a registered nurse, psychiatric social worker, occupational therapist, and psychiatrist. (Except for the psychiatrist, they were the same staff as before the establishment of the unit). Meetings attended by the client and her husband were held approximately once every two weeks. The meetings were mainly held in the ward but sometimes at home and also online. Since her discharge from the hospital, the patient receives home-nursing services.

Tomoko used to be isolated most of the time for over a year for "repeated undressing," "eating other people's food," and "restlessness." This isolation was terrifying and traumatic for her for a long time. She was also administered neuroleptics equivalent to more than 3000 mg/day of chlorpromazine for sedation. Hospital staff members made decisions about the course of care without the client. The decisions of the psychiatrist as the responsible person and the nursing team directly involved with the client took priority. The client was considered an unstable psychotic patient, and there was little psychotherapeutic involvement by the treatment team. The psychiatric social worker offered to assist with the discharge. However, the psychiatrist and nursing team considered discharge difficult due to the client's medical condition and prioritized medicated sedation to improve her symptoms. Her husband, Takashi, came to the hospital daily, but the treatment team limited the frequency of meetings and outings because they believed that seeing him would destabilize her medical condition.

The Dialogical Practice Team became involved and over 50 meetings were held. The client confessed her fear of confinement, low self-esteem, and feelings toward Takashi. High doses of neuroleptics impaired bowel movements and severely restricted her diet, and nutritional disorders and food theft from starvation may have occurred. The medications were reduced to a chlorpromazine equivalent of 650 mg/day, which increased the activity range. The client followed specific daily life routines, such as bathing and using a mobile phone with team members. Through these, Tomoko repeatedly stayed home overnight, and Takashi listened to her and created a safe situation for her. She was discharged and was able to gradually perform household chores.

Coding of Remarks

The transcripts were coded and classified according to the content of the utterances. YK and MJ independently prepared the code which was agreed upon through discussion.

Feelings toward the family
- The importance of believing in the family (Tomoko)
- Meaning of supporting the client as a family member (Takashi)

Feelings toward self
- Guilt (Tomoko)
- Anxiety about being trapped (Tomoko)

Memories and emotions surrounding the treatment
- Relationships with staff (Tomoko)
- Adjustment to life in the hospital (Tomoko)
- Previous situation (Takashi)
- Not wanting to rely on medication (Tomoko)

Hope and meaning
- Recovery after discharge from the hospital (Tomoko)
- Resources (Tomoko)
- Meaning of dialogue practices (Tomoko and Takashi)
- Significance of discharge from hospital (Tomoko and Takashi)

Tomoko stated that she felt a strong sense of anxiety, wondering if she would end up being trapped and dying. At such times, she repeatedly spoke of how her family was her best supporter and how grateful she was for her relationship with the staff. She also stated 12 times that she believed in her family and staff members. She reiterated an intense feeling of guilt, saying, “I hope you forgive me,” and that she “does not want to feel like a test subject” when taking medications, and that she “cannot think straight when I am working.”

Takashi emphasized the differences between the previous situation and the introduction of meetings. He believed that psychiatrists would lock Tomoko up if she screamed. The doctor would only give her medicine. “I was envious of people in the general room. I could not think of leaving the hospital,” he said, “The only options were hospitalization and medication,” and “(the staff) could not help Tomoko and neglected her.” Once the treatment meetings were introduced, he had mixed feelings because although the staff were the same, their relationship changed dramatically. However, he has found fulfillment, saying that he and Tomoko have learned that they too can take the steering wheel when it comes to treatment and that the meetings have been a small ray of hope.

Reflection of the interview by treatment team members

Author MJ: As a psychiatrist, I feel guilty of keeping my clients in isolation for a long period of time. (In Japan, isolation is ordered by a psychiatrist who is nationally certified in psychiatric behavioral restrictions). We talked as much as possible, but I think we needed to talk more with all of the nursing staff. I feel that the process has made progress, mainly through the voices of clients and network members. I feel that reducing medication use is a very important process because it restores activity and eliminates some medical challenges. Through repeated meetings, I felt that the trust between all participants was strengthened. As a result, behavioral restrictions were reduced.

Author YK: Priority was given to resolving behaviors considered superficial symptoms in the previous ward and individualized care was limited. Before the introduction of treatment meetings, I was very distressed because I wanted to respond to the patients' sincere desire to go home, but individual involvement by each professional was not enough to create an organic link. After the introduction of treatment meetings, we were able to meet these needs. I observed that through repeated opportunities to listen to voices of clients and network members, individual involvement became more organic, each person's resources came alive, and a significant change was created.

Visiting Nurse: The visit started after discharge from the hospital, and at first, there was some anxiety about forming a trusting relationship. Throughout the meetings, the understanding of a person’s struggles and wishes improved. I began to see the individual living as a person, not as a sick person. There are conflicts in the daily relationship.

But there is the relief that I can talk about the conflicts in the meeting. And simply accepting me, even if there is no answer, has been a source of sustenance for continuing home nursing.

DISCUSSION

The spiral structure of theory and practice in the meaning-making process

Various theories have helped us to make meaning in meetings with people with psychosis, which is particularly common in the unit; the phenomenological perspective of Seikkula (2019) was the starting point for our journey toward under-

standing. Knowing the possibility of psychosis as a response to an extraordinary experience brought to us, as listeners, the reality that there may be unspeakable experiences. Second, intensive psychotherapy with people with chronic psychosis, as described by Karon (2003), also provided many clues toward understanding clients who have been dealing with mental illness and loneliness for decades and how important it is to try to understand them honestly. Deamer and Wilkinson (2021) provide further concrete clues to understanding what clients say from a linguistic perspective. Sometimes, we attempt to use metaphors to comprehend what is beyond our understanding. What we do not fully understand may be retained as ideas and beliefs that are generated.

Meaning making is essential to everyone. This is especially true for significant and strong emotions. For example, there have been reports of how people who have experienced disasters (Park 2016) and chronic pain (Ferreira-Valente & al. 2021) make sense of their experiences. A meta-analysis also showed that interventions promoting life-meaning-making improved coping and resilience (Manco & Hamby 2021). This process progressed in our mind in a spiral structure of learning theory and reflecting from practice. This process also affects the meaning of our work. When meaning-making is shared with team members in meetings, the meaning-making of work for team members becomes more precise, which has a positive impact on the way the treatment team works, creating an excellent spiral process.

Reflection from the interview

Overall, much was said about the treatment before the team was involved, and it was assumed that the impact was significant for clients and their families. Traumatization and re-traumatization by medical treatment can have a severe impact on clients (Center for Substance Abuse Treatment (US) 2014). Frequent references to medication and efforts to adjust to group living in preparation for discharge suggest a power gradient between parties and staff. Goffman defined a total institution as a place of residence and work where many individuals in similar circumstances live a closed and formally controlled daily life together, cut off from the inclusive society for a considerable period. It attempts to capture the various processes of "deprivation" and "resistance" against patients in psychiatric hospitals from the "perspective of the mentally ill, the inmates" (Goffman 1961). While Tomoko may have experienced a range of emotions while escaping such a situation, she also tried to adapt as a subject.

Tomoko's frequent mention of trusting herself, her family, and staff suggests that she chose to trust the process despite enduring anxiety. She also shared that although she has made a remarkable recovery and has been in rehabilitation for more than a year

after her discharge from the hospital, she repeatedly and vehemently asks for forgiveness and is still suffering from trauma. Each person mentioned several resources that had emerged from the practice of dialogue, reaffirming that they had significantly impacted the process of transitioning to the community. In the treatment meetings, unimaginably intense and undifferentiated feelings and sensations were shared in the form of words, and the way of being that had to be managed in the process was resolved. Even if we do not understand the meaning of a conversation with a client, we should try, as much as possible, to suppress the idea of "pathological," focus on the speaker's or listener's own emotions, be in the relationship here and now, and be in the place with the network members or unit members, and subsequently, we will achieve the moment of meaning-making. The interview process overlapped significantly with our team's challenges and efforts to resolve them.

Implementation and de-Implementation

We experienced a step-by-step shift and reversal of values in a psychiatric hospital in Japan where the conventional methodology is mainstream. Considering ethical issues, such as system-centrism and suffocation, the team gradually shifted its values. Over the past five years, we have learned the principles of OD (Seikkula & Arnkil 2014) and how to listen to and share voices in crises that arise between clients and their families. Mainly with clients hospitalized for years and their network members, much of the learning came from the changes that occurred during and between the repeated network meetings. In the meetings, the need for medication was also revisited, which also helped us understand.

However, psychiatric symptoms are generally regarded as incomprehensible. Therefore, it has been customary to counteract the symptoms with medication. Even after we have become aware of dialogical practices, traditional values have influenced us for a long time.

The process, therefore, required learning and "implementing" the updated values and knowledge and "de-implementing" (Leigh & al. 2022) the traditional values. Namely, traditionally harmful or inappropriate interventions should be stopped.

In research in Western Lapland (Bergström & al. 2021; Bergström & al. 2022; Seikkula & Olson 2003), meetings were held immediately after a crisis. On the other hand, many of the clients we met in our practice felt that they had already been too long in a prolonged crisis. In 2017, the author MJ visited Keropudas Hospital and asked

therapist Kari Valtanen "How can we have a dialogue with clients diagnosed with so-called chronic phase schizophrenia with prolonged hospitalization?" He suggested, "In the same manner." Through practice, we believe we have gradually understood what this means.

The implementation of OD also requires de-implementation of traditional methods. Even if traditional culture forms the central value system, the meeting space can still be opened and conversations can still occur. However, the implementation of OD is limited because meaning-making may be inadequate. This is because if we do not fully understand the meaning of our clients' words and actions in our daily interactions, our intolerance for the unknown and uncertainty will persist. What is essential for de-implementation is not to condemn conventional methods, but to achieve a situation where traditional methods are no longer needed.

In a systematic review, Leigh and colleagues (2022) found that clear barriers to de-implementation included a "lack of reliable evidence to support de-implementation," "entrenched norms and clinicians' resistance to change," and "patient demand." In this context, it is essential to build credible evidence to support de-implementation. Therefore, we consider a more profound meaning-making process necessary for implementing OD. We often regarded fragmentation and segregation as no longer essential once the meaning was understood.

CONCLUSION

In de-implementing traditional psychiatry and implementing OD in Japanese psychiatric hospitals, it is necessary to base the treatment on a horizontal relationship. Through repeated meetings and listening to the voices of clients and network members, horizontal human relationships are created as the foundation of the implementation. As a result, meanings and feelings are shared.

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