The History of the Open Dialogue Approach in the United States

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"Open Dialogue"—a network approach to severe psychiatric crises developed at Keropudas Hospital in Tornio, Finland--first began to attract notable attention in the United States a decade ago, although many ideas and practices that influenced its evolution in Finland actually came from the US. In particular, the Finnish team refined and advanced elements of US family therapy. Among these US linkages are Gregory Bateson's Palo Aalto research on communication (1952-1962); Ross Speck and Carolyn Attneave's network therapy for schizophrenia that flourished in the late sixties at the Philadelphia Child Guidance Clinic, and Harry Goolishian and Harlene Anderson's collaborative-language approach that emerged in the eighties at the Galveston Institute in Texas. While holding in mind that Open Dialogue is indebted to these and other US ancestors, this brief essay will focus on the recent wave of interest in the Finnish approach.

Starting in the mid-to-late 2000s, receptivity to Open Dialogue in the US appeared alongside the emergence of new cultural trends. They include (1) a growing and widespread disillusionment with a fragmented, overly medicalized, and often ineffective mental health system; (2) rising psychiatric disability rates; (3) theoretical and empirical challenges to biological psychiatry; and (4) the ascendant visibility and voice of the recovery movement that, established and led by ex-patients, has become broadly embraced by clinicians, researchers, funders, and administrators advocating for an entire system overhaul.

During this same period, after studying the approach on a Fulbright at the University of Jyväskylä, I had begun working on a US Open Dialogue research study in close collaboration with Open Dialogue developer Jaakko Seikkula. With a rise in interest in

alternatives to the present system, our work eventually attracted support and became the Open Dialogue Approach Implementation Study at the University of Massachusetts Medical School, "UMMS,"(https://escholarship.umassmed.edu/pib/vol9/iss10/1/), 2012-2017. This, in turn, has germinated new offshoots at Emory University in Atlanta, GA and the University of San Diego ,California (https://medschool.ucsd.edu/som/psychiatry/research/open-dialogue/Pages/default.aspx). At the same, I established a training program, the Institute for Dialogic Practice, "IDP," (www.dialogicpractice.net), now located in New York City, which has trained virtually all the team leaders (fully training many entire teams) and independent practitioners in the US currently using this approach, becoming now an international certification program for Open Dialogue.

As a clinician, researcher, and educator, I was interested in this way of working as a flowering of the systemic family therapy tradition that I had embraced, practiced and taught for fifteen years before in a variety of professional and academic settings. Based on the work of Bateson, this branch of family therapy sees language and communication as central to the therapeutic process. Open Dialogue has arisen from an intersection between this form of family therapy, enhanced by the above-mentioned US network and language approaches, with the philosophy of Russian philologist Mikhail Bakhtin and his concept of dialogue as a model of the living world. As a university teacher/researcher in Finland in 2001, I was able to study Open Dialogue in depth, both academically and ethnographically as a participant-observer, which formed a professional watershed, radically altering my work (Olson, 2015; Seikkula & Olson, 2003).

When I returned to Massachusetts in 2002, I began adapting dialogical principles to my clinical practice as a family therapist and saw much more rapid recovery with teenagers and young adults experiencing eating problems, severe depression, and early psychosis. I was thus inspired to explore the broader feasibility of this way of working in the US and found the group of like-minded researchers at the University of Massachusetts Medical School that was interested in doing a clinical study. But, after several attempts spanning 2003-2007, we were not able to obtain funding, and the project languished.

At the same time, reports of outcomes achieved by Open Dialogue for first-time psychosis became more widely known in the US: e.g. 80% of patients were studying, working, or looking for a job after 5 years (Seikkula at al., 2006). I was invited to give talks about the approach to local and national groups. Everywhere, from medical schools to community mental health centers, people seemed enthusiastic about it, though daunted by the many barriers to putting such an approach into practice within our economically-restrictive mental health system.

While I could not see a discernible future for Open Dialogue in the US at the time, I kept having the feeling that something important was ahead the way you can hear the distant sound of rapids while going down a river. I just did not know what.

Then, in 2010, American journalist Robert Whitaker published his book, Anatomy of an Epidemic. At the end, there was a slim chapter about Open Dialogue, entitled "Solutions," which called attention to its remarkable outcomes for first-time psychosis. Whitaker's book became a bestseller and provoked widespread interest in finding alternates to reductionistic, biomedical psychiatry that he heavily critiques. This set in motion the formation of a new, alternative funding agency, the Foundation for Excellence

in Mental Health Care, "FEMHC," that began raising funds for Open Dialogue. In 2012, I, together with my UMMS team, finally secured funding for the UMMS project from FEHMC.

The University of Massachusetts Medical School Research Study: "Preparing the Open Dialogue Approach for Implementation in the United States"

From 2012-2017, Doug Ziedonis, then the Chairman of the UMMS Department of Psychiatry, and I co-led the research study at UMMS and created a research team comprised of UMMS mental health services researchers, Doug's national contacts in the recovery movement, and Seikkula and other international colleagues from my network in Europe.

The results of the UMMS study are twofold. First, in the first three years of the project, following the NIMH guidelines for research development, we developed the fidelity tools for psychotherapy and organizational assessment. They are "The Key Elements of Dialogic Practice in Open Dialogue"(Olson, Seikkula, Ziedonis, 2014), "The 10 Organizational Criteria"(Ziedonis & Olson, 2015) and two companion pieces, "The Open Dialogue Therapy Adherence Fidelity Scale," (available in Olson, Seikkula & 6 Ziedonis, 2014) and a rating manual (Ziedonis, Small & Larkin, 2018). The double focus of the fidelity work corresponds to the 7 basic principles of Open Dialogue that stipulate both a particular kind of treatment system and particular form of therapeutic conversation as requisite to foster dialogical–network interaction.

These research materials have created new possibilities for Open Dialogue research and training. This work enabled the development of the first randomized-design study of

Open Dialogue, which is taking place actually in UK, entitled ODDESSI (The Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness Study). The quality of training, rooted now in the key elements and fidelity processes, has also improved.

Second, we launched a pilot clinical trial at Grady Memorial Hospital in Atlanta, GA. This research is still underway and sustained by new funding from FEHMC. The aim of this study, which provides clinical care for 20-24 families, is to obtain reliable, preliminary US outcome data, if promising, could justify a similar undertaking as above, the launching of a large-scale, randomized-design study of Open Dialogue in the US.

The Origins of the Institute for Dialogic Practice

In 2011, in response to many requests by community practitioners to provide Open Dialogue training and supervision, I established the Institute for Dialogic Practice in Northampton, MA. IDP initially offered a systematic, two-year training program in Open Dialogue, the first such initiative outside of Finland. The faculty included Jaakko Seikkula, Birgitta Alakare, the late Markku Sutela from the original Finnish OD team, Belgium psychologist Peter Rober, and myself.

In 2017, I moved the program from Massachusetts to New York City, and developed a 3-Year International Certification Training Program for practitioners and trainers. It is delivered in a series of four intensive 5-day sessions per year in order to meet international standards for certification in Open Dialogue. There is a didactic seminar focused on theory, in addition to clinical supervision, and family-of-origin exploration emphasizing the trainees' self-development.

With the growth of the program, new faculty joined including New York psychiatrist Nazlim Hagmann, Finnish therapist/consultant Jorma Ahonen, nurse/family therapist Mia Kurtti from Keropudas Hospital, and the UK psychiatrist and ODESSI researcher Russell Razzaque.

This training program has spawned the development of a US network with Open Dialogue practitioners and researchers at Harvard-affiliated McLean Hospital (Rosen & Stocklosa, 2015); Boston Dialogic Center; Yale University; Advocates, Inc. (Gordon et al. 2015); ACCESS: Supports for Living in New York; Grady Memorial Hospital; the University of New Mexico Medical School; First Hope, Contra Costa County, CA; University of California, Santa Barbara & San Diego; Vermont's Howard Center; the National Empowerment Center; and the Massachusetts-based residential programs, Gould Farm and Windhorse. Our Institute has trained approximately 60 practitioners to an advanced-level, and many more in shorter trainings.

Open Dialogue: It Significance for-- and Evolution in--the US

In the course of doing all of this, I have deepened my appreciation of the significance of this approach for the US. In particular, I have become increasingly appreciative of the social justice resonance of Open Dialogue, especially since training the team at Grady that mainly serves low-income residents from the African-American community. This relational approach builds networks and respects everyone as a human subject, with voice and agency, rather than turning them into objects of intervention.

Moreover, the need for this kind of care in the US could not be more pressing. In particular, racism, poverty, trauma, immigration, isolation, violence, and alienation, all

widespread features of US society, correlate with higher rates of psychosis. Most of the US ideas and practices that influenced Open Dialogue came out of work with oppressed and disadvantaged people burdened with the added stigma of a psychiatric diagnosis. Open Dialogue in the US thus represents the reinvigoration of an older contextual, ecological way of thinking and helping that was born here in the US from family therapy and has been fully eclipsed here by two decades of a hegemonic, decontextualized, reductionistic biological psychiatry.

Along this line, we have begun widening " the ecology of ideas," to borrow from Bateson, to improve the sources of identification and responsiveness that can inspire our US trainees and fuel their creativity and capacity to be in dialogue with their own settings. For this reason, our training incorporates the whole brilliant tradition of dialogical-reflecting ideas and legacy of communication-based approaches that goes back decades and forward into the future as a basis for fresh possibilities and ongoing evolution.

SAMHSA Emerging Models and Promising Practices to Support Caregivers

Finally, a sign of the growing acceptance of Open Dialogue in the US is its recent designation as a "Promising Practice to Support Family Caregivers" by the Substance Abuse and Mental Health Services Administration (SAHMSA) which is the chief governmental funding agency for mental health programs in the US. I was part of the national committee that developed a toolkit (resource materials and a video) to increase understanding and awareness of this approach addressing both the public and professional community. This designation also means the allocation of increased federal funding: one of our IDP trainees recently obtained a significant SAMHSA grant to develop an Open Dialogue acute crisis service at his agency in New York.

The Future?

Over the last decade we have successfully brought Finnish Open Dialogue to the US by conducting important research, developing the IDP, and attracting funding. Yet, this approach is still not widely available, and our work is hardly done. It is important to sustain the projects described above and continue to build a solid US foundation in research and training to allow this humanistic way of working to become fully viable and available in the US.

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