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Open Dialogue-a Contribution to a Healthier World: Threat or Chance?

Werner Schütze[1]

[1]Formerly Department for Psychiatry, Psychotherapy and Psychosomatics at Havelland Kliniken GmbH in Nauen/ Brandenburg, Germany.

Corresponding Author: Werner Schütze, Formerly Department for Psychiatry, Psychotherapy and Psychosomatics at Havelland Kliniken GmbH in Nauen/ Brandenburg, Germany, **Tel:** 00491739316182; **Email:** dialogischepraxis@gmx.de

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ABSTRACT

In this article the dilemma of psychiatry as a medical science is outlined as well as options, where we as psychiatrists should turn to. Open Dialogue as a therapeutic approach to severe mental health crisis is introduced and described in its principles and elements. A case description illustrates how principles and elements are set to work. Connections to the upcoming Peer Movement are drawn as well as to EU-Legislation about Deinstitutionalisation and the UN-Convention of Civil Rights for People with Disabilities (UN-CRPD). Finally the difficulties in implementing such a comprehensive approach are outlined to get closer to an answer, whether this kind of change has more of a chance or tends to be a threat.

INTRODUCTORY REMARKS

Since a couple of years it is obvious, that psychiatry as a science is facing a fatal crisis, but resistance to acknowledge some facts, that showed up, is strong within the profession, and that for many reasons. Still like in the middle ages the ambassadors of the new knowledge get kind of "burnt" on the bonfires of certain journals, as if to kill the messenger who brings in bad news. It looks like some facts are too disturbing to have a closer look at them. And we don't have to name it a "Copernican Turn" what is happening, it is more that we gathered knowledge that does not fit the mainstream assumptions in psychiatry. In this I follow Pat Bracken [1], Bob Whitaker [2, 3] and Peter Gøtzsche [4] as well as some others, who have been dealing with different aspects (Joanna Moncrieff [5], Volkmar Aderhold [6, 7], Stefan Priebe [1-8] and P. Bracken [1] sum up what we gained through what is called scientific research in the last decades and it is very sobering to imagine the billions of Euros spent. What for? Yes, as much as nothing. They could not lift any secrets of the brain as much as to be helpful for our patients. The same is true for brain imaging techniques and genetics. Robert Whitaker has had a closer look at the longterm outcome of different kinds of studies concerning different kinds of psychiatric treatment and comes to the conclusion that following the guidelines of medical – pharmacological treatment as usual leads to an outcome worse, than we would have expected and those patients who manage not to fall into the desired "compliance" and refuse to take long term medication, have better chances to recover and be included in more sufficient working and living conditions. He also revealed the way that business interests of the psychiatric profession and big pharma met in a fatal way for the benefit of the two, unluckily it turned out to be a disadvantage for the patients. He also revealed through epedemiological data in western countries a fourfold rise of disability allowances for mental health problems and connects it to the dominant treatment system. Peter Gøtzsche [4] as head of the Northern European Cochrane Association investigated the scientific background of the admission of certain substances to the market and revealed criminal power behind it. Joanna Moncrieff [5] managed to show, that theories about a chemical imbalance in the brain in the case of mental illness is nothing but a fairy tale, just a seemingly plausible invention. Stefan Priebe as a socially oriented psychiatrist has become the "mockingbird" of Psychiatry. He writes about the missing results of the investments in research over the last decades and its meaninglessness for the therapeutic endeavors. So we work in a mental health system that is built on wrong assumptions, produces more problems than it can solve, is more devoted to money and its implications than to those citizens, who are facing severe crisis and thus getting dependend on

support. What a mess, we might say, and yes, it is. But the situation is far from being hopeless. Luckily we know a lot about how we could improve our attempts to offer help, that can be not only accepted but also helpful!! By now, we know from the experiences in the Soteria Movement,(Mosher [9, 10], Ciompi [11, 12] the results from longterm studies(Huber, Ciompi und Müller, Vermont Study, Harrows, Wunderinck, West- Lappland)the acknowledgement of human wisdom through philosophy, Buber [13], Bateson [14, 15], Developmental Psychology (Trevarthen [16, 17], Stern [18] Reflective Processes and Open Dialogue (J. Seikkula, T. E. Arnkil [7,8] enough to know, in which direction we should go. science made the race and we have to admit, they had and still have fantastic results in medicine as well as other disciplines. But then there came up the idea to apply this approach of looking at smaller and smaller parts of living organisms as human beings, first brain architecture, than nerves, followed by research on cells and synaptic connections, now on an intracellular level of mitochondria or membranes. The price they were willing to pay is named decontextualization, which has lead to fatal consequences in dealing or being with human beings. They became kind of special mechanisms, were robbed their dignity and treated as animals. So it happened in the history of psychiatry, when torturous therapies were applied, and still are applied. And all that in the name of science. But shade and light go together, and where developments get out of balance a countermovement is provoked. And so we can see the upcoming changes, supported and pushed as well by a stronger and stronger acting peer movement, as a reaction to the uncomforting, disturbing and unsatisfying acts in the usual psychiatric treatment system. And where does it lead to? I am sure that we owe a lot to this movement of peers and a stronger sense for the possibilities of full recovery after severe mental health problems is growing. They helped us professionals to see some phenomena in a different perspective and succeeded in making their" facts" and ideas public. Now the WHO, WHO-EU, Unicef, Mental health Europe and other organizations stand for the rights of disabled people (UN- CRPD), engage themselves for Human Rights for everyone and promote Deinstitutionalisation and Inclusion as well as the integration of experienced experts (EX-IN, Peer-Movement).

If now a kind of new way of organizing therapeutic support shall be introduced, it should match and discuss all the issues mentioned above. So make up your mind yourselves:

OPEN DIALOGUE: WHAT IS IT?

Open Dialogue, as an approach to acute crisis in the field of psychiatry and psychotherapy, has been introduced, developed and evaluated under guidance of the Psychologist Jaakko Seikkula and colleagues from Finland since more than 25 years, especially in the finnish region of Western Lapland. It developed on the basis of what is called Need- Adapted Treatment, which Y. Alanen [19] introduced into finnish psychiatry in the beginning of the eighties of the last century. It is very much connected and enriched by the Norwegian Psychiatrist Tom Andersens works on reflecting processes as well as his view on relations as a social constructionist or contributions on collaborative learning. The revival of dialogical thinking is based on works of M. Bahktin, Voloshinov [20] and Vygotsky, until now widely unknown in a so called "westernized psychiatry"and theory. There is a Network, called the "International Meeting for the Treatment of Psychosis", in which groups and organizations , mostly from Scandinavia and Finland meet once a year since 1996 to talk about practical issues in developing reflecting processes and Open Dialogue at their local level. Until 2006 it had been widely unknown in other countries but from then on, people from Germany, Austria, England, US, Poland and even Australia got more and more interested. Up to now there is a movement in these countries to educate professionals, implement this method as well in inpatient as in outpatient treatment units. But what is it about?

IMAGINE

You are a member of the crisis team of your organization, which a few years ago had taken over the responsibility for the catchment area in which your town is situated. You are on duty today, and in case somebody calls, asking for help, it is your task to organize some kind of help. Suddenly the telephone is ringing, you answer it, and might say something like „Here is the crisis team Warsaw- Mokotow, my name is Ania ....what can I do for you"? Your interlocutor at the other end is sorry to bother you. She does'nt really know, if you are the right person to call, says maybe it would be better to call at the emergency room of the local hospital. You don't let yourself be irritated, because you feel responsible to help in this case, and there will be no attempt from your side to refer a person in need to another institution. "What kind of support do you need?" This could be your first question. The woman reports, that she is living in a suburb of the town, not far from your institution, together with her husband and her daughter, whom she is worrying about a lot since a couple of days. The young woman cannot sleep anymore, is standing at the window for hours, is talking to herself but doesn't answer, if she or her husband is asking her a question. Sometimes she points out with her fingers towards people passing by, claiming they were passing here only her. Since several days she would not eat properly, in fear of something in the meal that should weaken her to start to talk and more and more she would say things like she cannot bear this any longer. They as parents are

feeling more and more at a loss and in constant fear, something bad might happen to their daughter. Even the younger brother had given up to convince her, That she doesn't' have to fear anything and that it is all just delusions. A girl from the neighbourhood, who used to have a trustful and friendly relationship as well, couldn't do anything about it. They tried to go to a general practitioner or a specialist, but the daughter would not agree to leave the house. Finally the practitioner had given her the telephone number of the crisis team. Now you could ask, if they as parents would agree, if a team of 2 or 3 colleagues would visit their place or if something else would be more convenient. Now the mother answers, that at this moment it might be the best solution. Then you would ask, if there is anybody else who should be with them in the meeting and the mother proposed a time, when her husband and the younger brother, who lives in the same town, would be available, and, she adds that it might be a good idea, if the neighbour could come as well and offers to ask her, if she will have time. You fix a time in the late afternoon and together with two of your team members you drive to the place, where the family lives. Because of the things the mother told you about the daughter you came to the conclusion that some medical questions might come up, that could only be answered properly by a physician. That is why you asked the psychiatrist of your team to join you today. Arriving at the flat of the family, you find all the invited persons sitting around the kitchen table, only the daughter is still waiting in another room beside the kitchen and has made clear, that she is not interested in taking part in the conversation to come. You make a proposal to leave the door open. After you introduced yourself, you will in short words explain, what could happen the next hour. You will thank everybody for being here and thus showing their empathy for the young woman. Then you would ask, what they think should be talked about. And suddenly all kinds of questions concerning the well- being of the daughter are coming up like: "What is happening to her, what is it?" "Isn't that some kind of schizophrenia"? "Doesn't she have to be brought into a hospital?" "Does she need some kind of medication?" "Could it be, that she has been working too hard- didn't she talk about being bullied at her working place"? "How dangerous might it be, that she is not eating since some days"? "What could we do, to be able to talk to her again"? "Would we use enforcement to get her into the hospital for inpatient treatment"? "What if she would become suicidal"? The moderators will collect all these questions and offer to find answers together. They are taking care, that everybody's voice in the room is heard, that everybody can speak without being interrupted und thus guarantee, that as much perspectives as possible can be uttered. The moderators will give information to all the questions in a way, appropriate for the family, using everyday language, free of specialists terms and point out, that they are not here to decide, what is going to be done, but that they will do their very best to support the family (network) to find the best possible solution, that will fit their needs.

After nearly two hours the network members seem to be exhausted, tired and thoughtful. That is why you propose, to come to an end for today. You offer to come again the next day, or whenever the family would agree and mother and father appreciate this kind of help. They utter their relief and satisfaction not to use coercion. After this kind of talking together they feel much better and sufficiently informed and would like to have the next talk tomorrow at the same time. The other members of the network agree. The moderators then would ask the participants, if they would like to listen to some thoughts, they had been thinking themselves about what they heard and reflect this way. The people present agree, so the team starts to talk with each other. The mother gets tears in her eyes, as she listens, how much the moderators appreciate her loving and caring engagement during the last days, as well as the presence of all the others. Finally they agree on another meeting early afternoon the next day. Now the team says goodbye.

Stories about a person becoming psychotic like this, mostly all of us might have heard several times, though most of the times the story takes another turn, because very often the referral to inpatient treatment might seem the only solution. And there, medication would have been made urgent and possibly enforced.

In this case the story could continue in a way, that the team had a visit at the families place daily during the first week, only every second day during the following week and further on only once in one or two weeks. Overall the network meetings continued over a two-year period. It took two weeks, until the daughter was able to join this meetings. After that she started to leave the house again. She found a psychotherapist, because she wanted to talk about some things in the absence of her parents. The neighbour joined in only a few times, the brother stopped joining in after 2 weeks. Once they invited the employer, and the psychologist came twice. As for medication the psychiatrist prescribed a benzodiazepine for the night in the beginning. The use of neuroleptics was heavily discussed, but in the end the patient refused to take it. After a longer period with a medical sickness- allowance, she was reintegrated at her working place step by step, where she now is head of the purchasing department.

PRINCIPLES AND ELEMENTS

The OD- approach has developed certain principles, how to get organized in situations of acute crisis. These principles are

a challenge, may be a threat to our usual institution- centred way of working in the mental health field.

It starts with the demand for

• Immediate help within 24 to 48 hours

• Network orientation from the beginning

• Responsibility of the team on duty

• Flexibility in time and place to meet

• Psychological Continuity

• Collaborativity

These few principles already call for restructuring and reorganizing our daily routines, what sometimes almost seems to be impossible.

They are basic for organizing the network meeting as the "center court", where all the important information is given and where all decisions on what will happen next, are made.

Professionals as moderators help the people present to get into dialogue with each other. They give an example of how listening and talking to each other might work. "Respecting otherness in the present moment" is one of the aspects. Or something like: "I respect you as you are, and everything you say is important "(Both quotes from Jaakko Seikkula, personally delivered 2013)

To be able, to live this, it is important to deal with (and thus make it your own) issues of this new attitude or stance in working with people in crisis. These can be named as

• Tolerance of Uncertainty

• Dialogicity

• Polyphony

Tolerance of uncertainty means for example, that we as professionals no longer think, that we would have to tell people what to do. Every human being is seen as an expert of his own life and we will exchange information to be able to find the most fulfilling or promising solution. We are not responsible for what other people decide to make out of their lives. We as professionals no longer decide, what has to happen but support the members of the network to find the best solutions. Here is a demand for a big change in thinking about what we do and how we do it, for some of us it might be a threat to their professional identity. Every human being can be seen as an expert of his own life. And it is true as well, that we are all unique, not two people the same in this whole world.

Everybody is an exception. And there are some similarities, but that's it. We are used to looking for the "rule" behind individual behaviour, but Wittgenstein already reminded us, that it might be more important to look for the exeption in every meaning of individual utterances.

Dialogicity means in this place that life in itself is dialogical. There is a constant exchange between me and others present, some think it in a way of everything being connected with everything. This is in contrast to our scientific history since the age of enlightenment of revealing more and more parts of something, separate it from its natural surrounding and thus create ways of decontextualizing living phenomena. And even if science has produced amazing and astonishing results, we have to seriously consider, if this can also be applied to living beings or organisms.

There is a constant exchange of our organism with its surroundings, of which other organisms can be a part. Through breathing and our senses we constantly exchange "data" that are processed by our nervous system. This results in an ongoing change in ourselves, and we cannot step out of it.

Dialogical being is not reduced to verbal exchange but includes all our bodily reactions, which in themselves are based on feelings. And is it still that way that we are used to divide our thoughts in "belly"- thoughts and "reasonable" thoughts. Is it not more appropriate to see it all derived from feelings? Because when do we ever experience just the "one" pure feeling? Don't we have to deal with contradictory feelings, sometimes more, sometimes less, dependent on what we see as a problem? I am thinking that words and rational utterances are the compromise between this contradictory feelings. That would be something to discuss. And all this thinking and feeling streams along a time- vector, a stream in which we flow along, through whirls, over shoals with rocks in our way or even shooting the rapids. It is life that provides all this beside the nice and calm waters we can also ship or drift along, gazing at the sun, do some fishing or just watch what is going on.

Thinking about dialogicity we come across an important idea, which we should get more and more aware of. It is called the *present moment*

It is about people meeting each other in an unusual intense way. It lasts only a few seconds, but it is filled with an enormous power. Daniel Stern [21-25] observed it between mother and baby/infant, but we can experience it in all kind of relations, that can admit closeness. It happens in everyday life as well as therapy and is something we strive for because of its unique quality. And it goes along with presence, openness, attunement and understanding. It requires to have "the courage

to be present" (Kissel- Wegela, John Stewart is talking about "communicating in moments that matter". Sheila McNamee speaks of the necessity of our "radical presence" to be there for another person. A very old idea, a heritage of human wisdom, rediscovered (M. Buber, "Ich und Du") [26-30].

The *polyphony* of life exists in many voices from many perspectives, which enriches our possibilities to learn as much as possible. That is why as many people as possible are invited to contribute from their experiences and knowledge. This makes us think about the importance of truth and objectivity. What is this? Nowadays people are fond of the achievements of evidence based medicine and treat it as an objective, that has to be followed, like for example guidelines for treatment of schizophrenia- but who would nowadays dare to define what that is! But then thinking about truth and science I have to think of all what has been done to mankind and especially to psychiatric patients in the name of science? Of some of the cures of that time we think in terms of torture now. What will further generations think about what we did? Will they condemn us as well?

So I dare to say: Please be careful and humble enough not to stress some objectives too much, keep in mind that maybe in this case your solution or hypothesis is not appropriate.

The well-informed reader will notice, that all of the ideas mentioned in itself are not really new. It is maybe just another way to put parts of the amazing puzzle called„ psychiatric, psychotherapeutic, philosophical, psychologigal, sciological and human knowledge "together.

Why has this become so interesting in the last years? Why do so many people register in training programs for a new approach without knowing what their benefits will be?

To get closer to possible answers to this question, we will have to look beyond the rim of our daily experiences and to find ideas and trends in society and different cultures that might fit in with the outlined approach.

At first there seems to be a discontent with rules, regulations and possibilities of the existing widely biological orientated therapeutic psychiatric system, which in itself is only part of a bigger environment which is now organized more and more after rules of the mostly neo-liberal "market" and possibilities of "budgets", that are set up for periods of one or two years, very similar to formerly called „plans"that had to be fulfilled. For the psychiatric field this can be damaging because of two, may be more reasons:

First: the usual period of severely ill psychiatric patients lasts longer than one, two or three years. So there can be no perspective on continuity.

Second: Budgets are set up for organizations and institutions, not for the individuals.

Third: The economization of relations leads in the field of psychiatric care, as well as in others, to the inevitable effect, that people earn their living with people being sick. To get more money, you need more sick people, so the logic of the system is more than contradictory if not dangerous and surely in contrast to the Hippocratic oath, all doctors have still to swear on.

Our society as a whole is open enough to find a composition of differences. If the biological foundations of psychiatric illness and certain assumptions (i.e."there is no cure for schizophrenia") are pointed out and stressed, there will raise a countermovement to point out, that there a many psychological reasons to experience a severe crisis and that there is no reason to give away hope for recovery. So we have a strong user movement in many countries round the world. They are organized on local, national, continental and worldwide associations and movements. They call themselves experienced, survivors, veterans, peers, voice hearers, activists, advocates, lecturers [31-33].

Thessaloniki (VI 2014) they create own ways to support themselves (f.e. Dan Fisher, eCPR) have to be involved in research activities (Diana Rose, SURE, UK) and are actively using social media or websites (madinamerica.com) to stay in contact and get informed. They publish books (A. Lauveng- I morgen var jeg altid en løve-) on their experiences or are invited to the conferences of professionals, to tell their story [34-40]. I dare to say, that the most we learned in the last years about what to do and what to change in the psychiatric field, we learned from those people, who recovered and are able to share their thoughts and memories with us.

Something similar happened in the field of carers (UK) or caregivers(US), and it is not just NAMI in the US, that has become an influential movement but also for example organizations in Germany ("Verband der Angehörigen Psychisch Kranker/ Deutsche Gesellschaft für Bipolare Störungen") in which relatives/ carers find a place and a voice to be heard as well. And then there is a very progressive UN Convention on the Rights of People with disabilities (UN CRPD) from 1975 complemented by papers and decisions of WHO authorities as well as Institutions of the European Union. I think all countries of the EU joined that convention and are requested to work towards the defined goals. Some of them do it by shaping a "Nationalen Aktions Plan"(national action plan) like Germany. Or The National Mental Health Protection Programm in Poland.

This UN Convention (CRPD) and derived programs and papers

of the WHO or European Union are very much concerned about human rights, inclusion of disabled people, access to proper help in the living environment, the least restrictive kind of care, and more. But to make it short, there is a strong demand for person centered care in the natural environment of the community.

Already in 1990 in the Declaration of Caracas it is written, that mental hospitals isolate patients from their natural environment, thus generating greater social disability and creating unfavourable conditions that imperil the human and civil right of patients. The advice from this declaration is to avoid inpatient treatment. This sure is another threat to those who devoted the most or maybe all of their professional life to inpatient treatment in bigger and smaller hospitals or departments. First there is their claim to "know" all about acute crisis and it's risks. Then there is this call for reducing hospital beds, which means, that the fear of losing influence and personal meaning goes along , if justified or not. And even more important, the economist running the hospital or institution will be in opposition, as long as this is a threat to the financial stability of the organization. It seems, that nowadays decisions in the field of mental health are not made by the specialists in the field, but by those who are in charge of budgets and money. This statement is not about putting the blame on anyone, it is just to show, how all of us are part of a bigger surrounding and development, in which many of us have lost influence or a possibility to argue against lack of money, nowadays used to shut down everyone speaking out against this.

Coming back to threats and chances we come to the conclusion that implementing an approach with the comprehensivness of the Open Dialogue Approach is a real challenge for the existing organization of psychiatric treatment services and the people organizing it. Even if the evidence is overwhelming, that including families and carers into the treatment process is the most promising and most cost- effective effort (R.Crane), we face a lot of obstacles.

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