Integrated Master in Psychology

THE PORTUGUESE OPEN DIALOGUE PILOT PROJECT – EVALUATION OF EFFECTIVENESS

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RESUMO

Objectivo: Este projecto-piloto de Diálogo Aberto (DA) em Portugal faz parte de um protocolo de investigação multi-nível baseado em Pocobello et al. (2016, manuscrito não publicado), que pretende avaliar a transferibilidade da abordagem DA para o contexto dos serviços de saúde mental do Norte Alentejano. Este trabalho avalia a efectividade do DA com foco na análise exploratória dos resultados clínicos pré e pós-intervenção.

Método: Os 7 participantes foram avaliados pré e pós- intervenção. As escalas aplicadas foram as *Clinical Outcome Routine Evaluation - Outcome Measure* (CORE-OM), *Brief Symptom Inventory* (BSI), *Global Assessment of Functioning* (GAF), *Lubben Social Network Scale* (LSNS6) e um questionário de satisfação. Devido à pandemia de COVID-19, os contactos com os candidatos e os participantes, o processo de inscrição, as reuniões de DA e os procedimentos de avaliação foram realizados na sua maioria remotamente.

Resultados: Diminuição da sintomatologia e melhoria do funcionamento global e da perceção do apoio social. O sofrimento psicológico (CORE-OM) correlaciona-se positivamente com a idade, melhores níveis de funcionamento (GAF) com educação superior e estatuto de empregado/estudante e percepção de apoio social (LSNS6) negativamente com o número de reuniões atendidas. O estado civil verificou-se ser um predictor significativo da participação nas reuniões DA. As prescrições psiquiátricas foram mantidas. Os participantes casados reportaram maior sintomatologia, comprometimento do funcionamento, risco de isolamento social e compareceram a mais reuniões. O programa recebeu uma avaliação muito positiva por parte dos utilizadores.

Conclusões: A diminuição da sintomatologia e a melhoria do funcionamento global vão ao encontro do reportado anteriormente na literatura sobre DA em relação a *outcomes* promissores, sendo interpretados como sugestões encorajadoras para investigação futura. Como limitações, sublinha-se principalmente a dimensão muito pequena da amostra, a curta duração do projeto, a falta de aleatorização e de comparação com outras formas de tratamento ou grupo de controlo, que impedem a significância e a generalização dos resultados. A disseminação do projecto, a acessibilidade e a adesão dos participantes, bem como o contexto das reuniões foram indubitavelmente afectados pela pandemia de COVID-19.

Palavras-chave: diálogo aberto, crise psiquiátrica, prática dialógica, abordagens democráticas, cuidados de saúde mental

ABSTRACT

Aim: This first Open Dialogue (OD) pilot project in Portugal is part of a multi-level research protocol, based on Pocobello et al. (2016, unpublished manuscript), which intends to assess OD transferability to North Alentejo mental health services. This work evaluates the OD effectiveness, focusing on the exploratory analysis of pre- and post-intervention clinical outcomes.

Method: The 7 participants were assessed through a multi-method approach, both pre- and post-intervention. The scales applied were the Clinical Outcome Routine Evaluation - Outcome Measure (CORE-OM), Brief Symptom Inventory (BSI), Global Assessment of Functioning (GAF), Lubben Social Network Scale (LSNS6), and a satisfaction questionnaire. Due to the COVID-19 pandemic, contacts with candidates and participants, the enrolment process, OD meetings, and the assessment procedures were performed mainly remotely.

Results: The findings indicate a decrease in symptomatology and an improvement in global functioning and social support perception. Psychological distress (CORE-OM) was positively correlated with age, higher levels of functioning (GAF) with superior education and employment/studying status, and a negative correlation between LSNS6 and meeting attendance. Marital status was a significant predictor of OD meeting attendance. Psychiatric prescriptions were kept. Overall, married participants reported higher distress symptomatology, functioning impairment, and social isolation risk and attended more meetings. The OD program received a very positive rating from users.

Conclusions: The findings on decrease in symptomatology and an improvement in global functioning match previous OD literature findings and confirm promising outcomes, while suggesting further research. The main limitation is the very small sample size, the short duration of the project, the lack of randomization and comparison to other forms of treatment or control group, which hinder the significance and generalizability of the findings. The project's spread, participant accessibility and adherence, and meeting setting were undoubtedly affected by the COVID-19 pandemic.

Key-words: open dialogue, psychiatric crisis, dialogic practice, democratic approaches, mental health care

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INTRODUTION

Open Dialogue (OD) is an innovative non-hierarchical organization of health service and mental health treatment focused on psychiatric crises founded in 1980s in Tornio within the Finnish Keropudas hospital. The OD approach derives from Yrjö Alanen's "need-adapted" treatment (1997; 2009) and is rooted in psychodynamic and family-oriented therapy. Dialogical and networked approaches have been combined for the purpose of building up network meetings — the key unifying and collaborative moment (Olson et al., 2014). The meetings intend to be a genuine therapeutic space based on meaning-making driven by dialogue to enable the understanding to unfold from multiple perspectives, where everyone present speaks in their own voice and decisions on what will happen next are made transparently and jointly. The OD's distinctive core, as informed by its principles (Olson et al., 2014) reveals itself by emphasizing everyday language and the stories of each person involved by valuing the significance of specific words and expressions emerging in the therapeutic encounter as relevant for the network, accepting uncertainty as part of the process, and preserving the lived experience language, which leads users to understand and address crises on their own terms instead of perceiving them as passive actors of their own lives. Crises, those to which the team strives at the onset to undertake an immediate response to reduce the likelihood of hospitalization, are faced as natural responses to challenging life events rather than as psychopathology, and listening becomes more important than the manner of interviewing (Andersen, 1995). By listening, one seeks to respond to each word previously spoken by inquiring or commenting reflectively to the other professionals about their thoughts in response to what is being said (Andersen, 1995; Seikkula, 2011) looking for meaningful explanations that may uncover the root of symptomatology, taking network into explorations they might not otherwise undertake, as well as to the full meaning of a sentence through the listener's response, and so on in a constant dialogical exchange. The richness of process itself stands out for its potential for overcoming crises by promoting here-and-now learning, recognizing, and embracing complexity, and cultivating radical presence by being genuinely in relation (McNamee, 2015). More voices, more contributions, more possibilities to go further through dialogue. By continually promoting the generation and sharing of meaning and by reflecting on polyphony (Bakhtin's, 1984; Vygotsky, 1970), which is expressed by facilitating different perspectives of network members (outer

polyphony), inner polyphony emerges, bringing up awareness of one's own words and moving away from the unconscious as lived experiences are put into words. Facilitators' inner voices of their own personal and intimate experiences also take part in the dialogical exchange in the way they adapt themselves to the present moment, a powerful component of the joint process of being in dialogue (Seikkula, 2011). Being transparent in the exchanges brings with it a sense of safety and security needed to tolerate the uncertainty that will be noticed throughout the process. By tolerating the uncertainty — a challenging stance — non-urgent decisions are postponed, thus gaining time for mobilising psychological resources, and reaching clarifications as multiple perspectives emerge and make sense of the narratives.

The systematic evaluation of OD has shown promising evidence, initially for schizophrenia group psychoses treatment and gradually extended to other mental health conditions (e.g., mood disorders, anxiety, suicidal ideation, etc.) in both short and long-term outcomes measurements, mainly in regards to functioning improvement (Gordon et al., 2016; Seikkula et al., 2003), higher rates of employability, and academic participation (Alakare & Seikkula, 2022; Aaltonen et al., 2011; Gordon et al., 2016; Seikkula et al., 2003, 2006, 2011). Also, reductions in psychiatric symptomatology (Cotes et al., 2023; Gordon et al., 2016; Seikkula et al., 2003), lower rates of relapses (Seikuula et al., 2003; Seikkula et al., 2011), suicidal ideation (Granö et al., 2016), hospital admissions (Altonen et al., 2011; Bergström, et al., 2017, 2018; Seikuula et al., 2003; Tuori et al., 1998), and dependence on disability and unemployment allowances (Alakare & Seikkula, 2022; Bergström et al., 2018; Lehtinen et al., 2000).

Due to the promising outcomes, there has been a gradual increase in global interest in OD over the last three decades (Buus et al., 2017, 2021; Cooper et al., 2020; Freeman et al., 2018; Gomis et al., 2017; Kantorski & Cardano, 2019; Kłapciński et al., 2015; Lakeman, 2014; Pavlovic et al., 2016; Pilling et al., 2022), which has already been adopted globally and adapted to each local's demands (Lima & Corsini, 2020; Pocobello et al., 2021; Stanger & Hefer, 2022; von Peter et al., 2019). In Portugal, OD has been implemented since 2020. Despite the needed adaptations, in order to assure OD fidelity, it is strictly required to maintain adherence to the 7 principles: Immediate help; Social network perspective; Flexibility and Mobility; Responsibility; Psychological continuity; Tolerance of uncertainty; and Dialogue and Polyphony; as well as to the

12 key elements: Two (or more) therapists in the team meeting; Participation of family and network; Using open-ended questions; Responding to clients' utterances; Emphasizing the present moment; Eliciting multiple viewpoints; Use of a relational focus in the dialogue; Responding to problem discourse or behaviour in a matter-of-fact style and attentive to meanings; Emphasizing the clients' own words and stories, not symptoms; Conversation amongst professionals (reflections) in the treatment meetings; Being transparent; and Tolerating uncertainty (Pereira et al., 2019; Olson et al., 2014; Seikkula et al., 2003).

The Portuguese population is known to have one of the highest ageing indexes in Europe (Fundação Francisco Manuel dos Santos - FFMS, 2022) and one of the greatest incidences of mental disorders (around 20%) and prevalence of psychological symptomology (23%) (Almeida et al., 2013; ERS - Entidade Reguladora da Saúde, 2023). In addition, Portugal is increasing its number of pharmacological prescriptions, with psychotropic (anxiolytics, antipsychotics, antidepressants), sedative, and hypnotic prescriptions increasing nationwide over the years (DGS, 2017), having already had one of the highest consumption rates of psychotropics in Europe in the past (Almeida et al., 2013). Alentejo is the region in Portugal with the lowest population density and the greatest ageing/longevity index of the country which might have motivated to be the selected region to implement the first OD pilot project. This region reveals worrying evidence at several levels, such as an illiteracy rate of 5.4% compared to the average of 3.8% in the whole national territory, as well as the greatest ratio of depression, anxiety (Direcção-Geral da Saúde – DGS, 2017; ERS, 2023), and unemployment status (INE - Instituto Nacional de Estatística, 2022). Alentejo has also shown a long-standing high suicide rate, despite slight improvements (DGS, 2017; ERS, 2023; Nunes, 2018). This public health problem extends beyond national borders; it is already the fourth leading cause of death among adolescents and young adults globally, yet resources for prevention remain scarce (World Health Organization – WHO, 2021b). Active ageing, a concept that is reflected in a set of policies and programs that enhance community participation and quality of life as people age throughout the life course and has already been claimed worldwide as a health priority (WHO, 2002), must be seriously considered by governments, even more so in a low-density and high ageing/longevity population region such as Alentejo (and Portugal, in general).

The fragility of the Portuguese health system represents a barrier to timely identify, treat, and follow up on mental health demands, which reflects in a recurrent use of hospital services (ERS, 2023), despite the fundamental right to timely access to affordable, preventive, and curative health care of good quality (European Commission, 2023). The scarcity of mental health professional resources in psychology and psychiatry services, which seem to be common in all care units and specialties of the National Health Service, plays a major role in the problematic Portuguese reality, with evidence of a shortage (or non-existence) of psychiatrists in primary healthcare units (ERS, 2023) and the current number of psychologists at 1 per 9687 inhabitants, which is almost double the recommended ratio of 1 psychologist per 5000 inhabitants (OPP – Ordem dos Psicólogos Portugueses, 2022). In addition, general and family medicine are the gateway to health specialties to which most people with psychiatric disorders have access (Almeida et al., 2013), which may partly explain the wide range of prescriptions to be undertaken by general practitioners (Madeira et al., 2022). Lack of systematization in IT systems impedes reliable data for primary healthcare unit response time compliance and general information on mental health care and resources in several regional health administrator agencies (ERS, 2023).

This first Open Dialogue project, approved and co-financed by the Directorate General of Health (DGS), was implemented by Romão de Sousa Foundation community team, which was constituted by 2 Clinical Psychologists with Advanced Specialty in Psychotherapy, 1 Psychiatrist, and 1 Coordinator (Clinical Psychologist) with a PhD in Psychotherapy. Both got Open Dialogue training to practitioner level in Finland, Norway, the USA, and Portugal. The project's external supervision was under the charge of Professor Mary Olson from Yale University and the Institute for Dialogic Practice in the USA. OD clinical practice was documented for audit purposes related to fidelity criteria.

The present work is part of a multi-level research protocol, based on Pocobello et al. (2016, unpublished manuscript) protocol for Italy, which intends to assess OD transferability to North Alentejo mental health services and focuses on the pre- and post-intervention clinical outcomes. Other levels of research part of the protocol not addressed here are: 1) Perceptions of the mental health service managers of the region; 2) Evaluation of the impact of OD training on Romão de Sousa Foundation community team; and 3) Adherence to OD principles.

METHODS

Study design

The program was designed to fit into an exploratory naturalistic observational study with consecutive referrals. A prospective follow-up design was used, with registration of the participants' outcomes at every 5 sessions for the period of 12 months.

Sample

Initially, this study included 11 participants who completed the enrolment procedure, which means that they were fully eligible and voluntarily consented to participate in the project; however, due to the general COVID-19 pandemic constraints and the fact that the OD meetings were unexpectedly adjusted to online, the final sample data ended with 7 participants. The first enrolment was in late February and the last was in mid-July 2020.

Socio-demographic characterization

Study participants were between 14 and 65 years old (38.14 ± 15.25). The final sample included 7 participants: 5 females (71.40%) and 2 males (28.60%). 28.60% (n=2) of them were employed, 2 were studying, 1 (14.30%) was on sick leave, 1 was on disability allowance, and 1 was retired. 71.40% (n=5) were single and studied at least until high school. 57.10% (n=4) lived in their parents' or relatives' homes. Table 1 (Appendix B) summarizes the socio-demographic characteristics of the study sample.

Clinical characterization

The participants' diagnoses, carried out by external to treatment/research team health professionals who accompanied the participants before entering the project, were as diverse as anxiety disorders, mood disorders, psychotic disorders, and others such as suicidal ideation and emotional dysregulation. The OD intervention rational to refer to patients as participants will be adopted from now on in the current text. In regard to hospitalization, 1 participant (14.3%) reported having had hospital inward or other residential structure admissions before the OD project. 42.9% of them (n=3) reported having attempted suicide, and 1 (14.3%) self-harm behaviour. 85.70% (n=6) were under psychiatric prescriptions. Participants were prescribed psychiatric medications prior to

the program's commencement, administered by external professionals who were assisting them before they joined the pilot project. Once enrolled in the OD program, the responsibility for any prescription fell upon the OD team psychiatrist, keeping the shared decision-making approach on this matter as well. There was only one participant whose previous psychiatrist retained the prescription responsibility, having also been invited to participate in OD meetings. In relation to residential context and extra-familial social relationship satisfaction, 57.20% (n=4) and 85.70% (n=6) reported not feeling satisfied, respectively. Table 2 (Appendix C) summarizes the clinical characterization.

Measures

OD feasibility was assessed through a multi-method approach pre-, during and post-intervention, covering clinical and life history interviews (qualitative) and quantitative measurement of psychological symptoms, global functioning, and social isolation. The scales applied were CORE-OM (Sales et. al, 2012, original from Evans et al., 2002); BSI (Canavarro, 1999, original from Derogatis & Spencer, 1982); GAF (Endicott et al., 1976); LSNS6 (Ribeiro et al., 2012, original from Lubben et al., 2006); and an overall program's satisfaction questionnaire.

Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)

The CORE-OM, translated to Portuguese (Sales et al., 2012), is a self-reported scale and consists of 34 items on a scale from 0 – Not at all to 4 – Most of all the time, distributed by 3 dimensions, which are Well-being (4 items), Problems/Symptoms – Depression, Anxiety, Physical and Trauma (12 items), Life Functioning – General, Social and Close relationships (12 items) and Risk – Self and to others (6 items) and measure psychological distress and essential aspects of psychological well-being over the last week. The Risk dimension is not considered a CORE-OM subscale but instead works as a clinical prompt for therapists and mental health services. The 34 items were formulated with different levels of intensity, including both experiences of high discomfort/psychological distress as well as situations that are relatively common in the general population. The cut-off is ≥ 1.25 with higher scores meaning greater severity of symptoms and distress. The Portuguese version of CORE-OM (Appendix D) presents good psychometric qualities

for internal consistency (α = .94), comparable to those found in the original one (Evans et al., 2002), save for the Risk dimension (α = .46).

Brief Symptom Inventory (BSI)

The Portuguese version (Canavarro, 1999) of the BSI from Derogatis and Spencer (1982) is a self-assessment questionnaire, referring to the last week, which consists of 53 items on a scale from 0 – Not at all to 4 – Extremely, which seeks to identify clinically relevant psychological symptoms. The scale covers 9 dimensions, including Somatization, Obsession-Compulsion, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism. The cut-off point is ≥ 1.7 for the Positive Symptom Distress Index (PSDI), where scores above suggest a higher probability of a person being emotionally distressed and below to be matched to a non-clinical population, and, on the Global Severity Index (GSI), the higher the scores, the greater the degree of symptomatology. The Positive Symptom Total (PST) is the count of all the items with non-zero responses, revealing the number of symptoms experienced. The Portuguese BSI (Appendix E) presented an overall adequate internal consistency, from α = .62 (Psychoticism) to α = .80 (Somatization); for the original scale, the values range from α =.71 on Psychoticism to α =.85 on Depression. The BSI is a short form of the SCL-90 (Derogatis, 1977), one of the most widely used self-report questionnaires (Canavarro, 1999).

Global Assessment of Functioning (GAF)

The GAF (Endicott et al., 1976; DSM-IV-TR, 2002) is a generic measure not intended for diagnosis used by clinicians, whose aim is to estimate the extent to which psychological symptomology impairs social and occupational functioning on a scale from 0 to 100 (Appendix F). It is subdivided into 10 sections, with scores below 21 being suggestive of some or persistent danger of hurting self or others, or occasionally failing to maintain minimal personal hygiene or gross impairment in communication; in contrast, if scoring between 91-100, there's an absence of symptomatology and of impairment clues, what is called superior functioning. Scores in the range of 41–50 suggest the presence of significant symptomology (e.g., suicidal ideation/severe obsessional rituals) or serious impairment in social, occupational, or school functioning; and, when scoring in the range of 61–70, even if the person exhibits some mild symptoms (e.g., depressed

mood/mild insomnia) or some difficulty in social, occupational, or school functioning, it is usually considered to maintain a well-functioning state. The aim of using this non-self-report measure was to increase the confidence of the self-reported measures and to analyse if there was concordance between both. Assessments were carried out by all members of the clinical team present who took part in the network meeting, rated blindly and immediately after the session, with the lowest number being recorded.

Lubben Social Network Scale 6 (LSNS6)

The Portuguese version of LSNS6 (Ribeiro et al., 2012, an adaptation of Lubben et al. (2006) is an abbreviated version of the original (10 items), considered more appropriate for social isolation risk screening, and consists of 6 items distributed in two self-report subscales (Family and Friends, with 3 items each), whose aim is to assess social isolation of elderly persons by measuring each network size and its relational dynamics. The scale (Appendix G) scores range from 0 to 30 answered on a 5-point scale from 0 – none to 5 – nine or more. The cut-off to be considered at risk of social isolation is <12 for the overall score, and even though the score is calculated for the total of the 6 items, it is considered existing marginal family/friends' ties when scoring <6 on each subscale, which indicates that, on average, the respondent has fewer than two people to perform the particular social integration functions assessed by the LSNS6. The internal consistency is adequate ($\alpha = 0.80$), as verified for the original scale ($\alpha = 0.83$). LSNS6 has already been validated in Portugal for other age groups than the elderly, with evidence of good psychometric properties (Villas-Boas et al., 2017).

Satisfaction questionnaire

Satisfaction survey on a scale from 0 – 10: “How satisfied are you with the services provided by the Open Dialogue Portugal Community Intervention Team?”.

Procedure

The pilot clinical and investigational project was announced in key locations, such as Casa de Alba - Democratic Therapeutic Community, pharmacies, social centres, town hall, and online, as well as in national partner institutions, such as the Commission for the Protection of Children and Young People (CPCJ), the Centre for Family Support and Parental Counselling (CAFAP) and

the Norte Alentejano Local Health Unit (ULSNA). Referrals were mainly done by family and network support members and by the candidates themselves.

The eligibility criteria depended on the presence of psychotic symptomology or other severe mental manifestations (non-probability objective sampling), age between 14 and 65 years old, voluntary health/community-support service usage, being able to understand the purpose of the project, and consenting to voluntarily participate in OD meetings with family and/or social network members. Initially, the minimum age set by the DGS was 18, but following the program's onset, the inclusion of one younger participant was exceptionally accepted by this agency. Feedback got delivered to all candidates after clinical screening, and the enrolment was completed after the informed consent procedure when fully eligible.

The OD program and research work were independent, so it was not mandatory to participate in both to be eligible for OD treatment, even though all the participants that voluntarily participated in the OD pilot project also consented to being part of this investigation. The teams were also independent, except for the coordinator, who has been involved in both clinical and research work. Most of the research team members have held or are holding positions at Romão de Sousa Foundation, the institution responsible for conducting the pilot project.

Due to the COVID-19 pandemic, contacts with candidates and participants, the enrolment process, and the assessment procedures were performed mainly remotely, as were the OD meetings; however, they were designed to take place at home or in a preferred place for each participant. As informed by OD principles, no meeting frequency and/or treatment plans were imposed in advance. Instead, it was jointly decided throughout each meeting according to each participant’s needs. Additionally, the study design planned for the questionnaires to be applied to each 5 sessions, but due to the adverse context, the data collection turned out to be more complex than planned, so it was decided to use only data from the pre- and post-intervention.

The research protocol was approved by the Ethics Committee of the *Universidade de Évora* (Case: GD/28982/2022/P1).

Data Analysis

A paired samples t-test was run for the analysis of the means' differences of CORE-OM, BSI, GAF and LSNS6 global clinical outcomes. Dimensions of each measure were compared by marital status using a t-test for independent samples. Also, a series of bivariate correlations (Spearman's) was run to examine possible relationships among variables, as well as a Simple Linear Regression to analyse the presence of predictors linked to OD meeting attendance. Both baseline and end of program assessments were included in the comparisons. All tests' assumptions were confirmed. IBM-SPSS 29.0 was used for the statistical data analysis.

RESULTS

The symptomatology registers a decrease at the final of the OD program. CORE-OM reached the cut-off point (1.25) for overall score, with 42.9% (n=3) of the sample registering a reliable change improvement, i.e., ≥.66 (Pereira, 2014). In relation to scale dimensions' scores, all three decreased at the end of the program. For descriptives, refer to figures 1 and 2 (Appendix H). Both the BSI Global Severity Index (GSI), the Positive Symptom Total (PST), and the Positive Symptom Distress Index (PSDI) register decreases, with PSDI reaching slightly below the cut-off point (≥1.7) and GSI registering a *p*=.052, marginally non-significant statistically. In relation to scale dimensions' evolution, all nine decreased, with statistical significance on the Obsession-Compulsion (t(6)= 2,611, p= .020 , g= .857); Interpersonal sensitivity (t(6)= 3,050, p=.011, g= 1,001) and Paranoid ideation (t(6)= 2,056, p= .043 , g= .675). For descriptives, refer to figures 3, 4, and table 3 (Appendix I).

Psychiatric prescriptions were kept, but with some changes throughout the program.

There was also evidence of a statistical significance increase (*p*=.023) with a large effect size (g=-.823) in global functioning level (GAF), reaching an approximate score of 66, a score above the cut-off point (61). Also, in regards to life functioning, at the end of the program, one of the participants who was on sick leave resumed work, and another started a graduation program and a peer-support program. For descriptives, refer to figure 5 (Appendix J).

The social network support perception (LSNS6) evolved from a nearly social isolation risk stage (<12) to a slight increase. This outcome was due to an improvement in support perception in the Friend's dimension, which at the baseline showed marginal ties evidence. The family's perceived level of support remained relatively the same. For dimensions descriptives, refer to figure 6 (Appendix K).

Table 4 summarizes the paired sample t-test by overall scores.

Table 4

Paired samples t-test for GAF, BSI, CORE-OM and LSNS6

	M (baseline)	SD (baseline)	M (final)	SD (final)	*t*	*df*	*p*	Hedges' G
CORE-OM (w/ R)	1,899	.883	1,252	0,343	1,712	6	.069	0,562
CORE-OM (w/o R)	2,093	.901	1,418	.388	1,761	6	.064	0,578
BSI – GSI	1,584	.744	1,078	0,350	1,921	6	.052	0,631
BSI – PSDI	2,017	.628	1,668	.224	1,803	6	.061	0,592
BSI – PST	40,000	6,506	33,571	7,743	1,733	6	.067	.569
GAF	57,714	10,468	65,714	11,398	-2,506	6	.023	-0,823
LSNS6	12,429	5,533	13,429	4,315	-0,548	6	.302	-0,180

Note. GAF – Global Assessment of Functioning; BSI – Brief Symptom Inventory; GSI – General Severity Index; PSDI – Positive Symptom Distress Index; PST – Positive Symptom Total; CORE-OM – Clinical Outcome Routine Evaluation - Outcome Measure; R – Risk; LSNS6 – Lubben Social Network Scale; M – Mean; SD – Standard Deviation; t – *Student's t-distribution*; *df* – Degrees of freedom; α = .05; *p* (one-tailed).

The statistically significant (R^2= .589, F (1,5) = 7,173, p= .044) linear regression model (Y= 17,000 + 20,500 * X) pointed to marital status (married) as a predictor of the number of OD meetings attended throughout the program. Table 5 summarizes the regression's coefficient t-test.

Table 5

T-test for the regression's coefficient

Variable	B	β	*t*	*p*
(Constant)	17,000		4,155	.009
Marital status	20,500	.768	2,678	.044

In general, in regards to distress symptomatology, in both the baseline and final periods, the CORE-OM and BSI overall scores and their dimensions were higher for those who were married compared to those who were single, but differences did not show statistical significance. The exception was for the CORE-OM Risk dimension at baseline as well as for BSI Depression at baseline and Somatization in both periods, where singles scored higher. The BSI Anxiety domain mean differences at the end of the program were statistically significant (t(5)= 2,628, p= .023, g= 1,849), with married participants showing more anxiety symptoms. Figure 7 summarizes the

CORE-OM and figure 8 BSI dimensions by marital status (Appendix M and N, respectively). In addition, in both the baseline and final periods, those who fit into the married status scored below for global functioning compared to singles, although no statistically significant mean differences were found. They also reported a lower social network support perception, with a statistically significant difference at the baseline on Friend's dimension (t(5)= -2,918, p= .004, g= -2,052); and at the end of the program on both the overall score and Family and Friends' dimension (t(5)= -3,759, p= .007, g= -2,644); (t(5)= -2,147, p= .042 , g= -1,510); (t(5)= -4,719, p= .003 , g= -3,320), respectively. At baseline, the married scored 0 (zero) on the Friends' dimension; at the final, there was a verified decrease in family support perception. Table 6 (Appendix L) summarizes overall scores by marital status (married/single).

The statistically significant correlations were linked to CORE-OM, GAF, and LSNS6 measure outcomes with age, professional situation, and OD meeting attendance, respectively. At baseline, the GAF score and the professional situation (employed or studying) were found to be positive and strongly correlated (r= .780; p= .05). At the end of the program, were found a positive and strong correlation between the CORE-OM score and age (r=.786; p= .05) as well as a very strong negative correlation between the LSNS6 and the total number of OD meetings attended throughout the program (r= -.912; p= <.01). Table 7 summarizes the baseline and end of the program correlations for socio-demographic characterization and clinical outcomes.

Table 7

Spearman's correlations baseline and end of the program correlations for socio-demographic characterization and clinical outcomes

		1	2	3	4	5	6	7	8	9	10	11
1.	**Age**	-		.316	-.327	-.579	.162	-.252	-.357	.286	.286	-.450
2.	**Nr. of meetings**[1]	.500	-									
3.	**Educational level**	.316	.474	-	.242	.171	.718	.399	.316	.158	.158	.239
4.	**Professional situation**	-.327	-.546	.242	-	.354	.780*	-.046	-.200	.164	.164	.248
5.	**Residential context satisfaction**					-	.156	.136	.270	-.116	-.116	.584
6.	**GAF**	-.180	.126	.638	.688		-	.227	.000	.450	.450	.018
7.	**BSI – IGS**	.357	.286	.316	-.091		-.198	-		.487	.487	-.245
8.	**BSI – ISP**	.214	.536	.474	-.164		-.018		-	.286	.286	.036
9.	**CORE-OM (w/ R)**	.786*	.357	.474	-.109		-.126	.500	.464	-		-.739
10.	**CORE-OM (w/o R)**	.739	.324	.558	-.009		-.018	.468	.450		-	-.739
11.	**LSNS6**	-.505	-.919**	-.399	.495		.000	-.414	-.667	-.559	-.518	-

Note. Below diagonal line: final scores; Above diagonal line: baseline scores; GAF – Global Assessment of Functioning; BSI – Brief Symptom Inventory; GSI – General Severity Index; PSDI – Positive Symptom Distress Index; CORE-OM – Clinical Outcome Routine Evaluation - Outcome Measure; R – Risk; LSNS6 – Lubben Social Network Scale; [1] – Sum; *p.05; **p<.01.

In total, were performed 160 OD meetings, mostly online (94%). Beyond the participation of the person at the centre of concern, there were a total of 150 presences distributed by 21 family categories (e.g., mother, sister-in-law, brother) which represented 28% of the attendance rate; the OD team represents 70% of this, with approximately 2 facilitators per meeting, and other professionals 2% (n=8). In relation to family mean presences, the minimum count of presences registered per meeting was 0 and the maximum was approximately 2 (.933 ± .818). There were no friends participating in the meetings.

The participants mean satisfaction score was 9.5, a very positive score. Along with the rating scale, participants left their written feedback about the OD program experience as follows: *"I'm feeling a lot of support; "I'm very reserved and quiet and you manage to get me to talk a little and bring out some problems that affect me the most; I really like the support of the whole team. It has been a great help for me and the family to overcome the difficulties we are experiencing; I*

really like the team, they helped me a lot; I hope they keep up the good work they do and help more people who need help like I did; Commitment in helping others solve problems.”.

DISCUSSION

The results of the pilot project indicate a decrease in symptomatology in both the CORE-OM and BSI indexes and dimensions, and an improvement in global functioning and social support perception. These suggest that participants experienced less psychological distress, became more socially engaged, and were less functionally impaired. At the end of the program, CORE-OM score have reached the cut-off point, and the PSDI (BSI) has evolved to slightly below the cut-off point, which indicates a higher likelihood of being matched to the non-clinical population (Canavarro, 1999), just as all BSI indexes and sub-dimension scores reached below the clinical population scores of Canavarro's study (1999). Despite overall improvement, symptomatology associated with Obsession-Compulsion, Interpersonal sensitivity, and Paranoid ideation dimensions (BSI) decreased significantly. The highest-scored dimensions are in line with the diagnosis profile of the investigation sample, mainly Mood and Anxiety Disorders, which suggests an adequate discriminant quality of the BSI (Canavarro, 1999). The correlations (Table 8 on Appendix O) between dimensions at baseline shows that, similarly to Canavarro's (1999) findings, Obsession-compulsion dimension is correlated with Anxiety and Psychoticism; Interpersonal Sensitivity with Psychoticism; Hostility with Psychoticism; Phobic Anxiety with Anxiety and Psychoticism with Depression. Also, perceived psychological distress (CORE-OM) was found to be positively correlated with age; however, the literature is heterogenous about these results. It seems to be more dependent on global contexts, life course happenings, risk or protective factors, and health concepts in the study designs than age per se, which hinders inferences on this matter (Almeida et al., 2013; Jiménez et al., 2017; Jorm, 2000; Jorm et al., 2005; Newmann, 1989; Schieman et al., 2001; Schönfeld et al., 2017; Snowdon, 2001; Westerhof & Keyes, 2010). At baseline, there was no significant correlation with age. This may be explained by the fact that one of the participants who was a young adult scored the highest for psychological distress (CORE-OM), although the ones in the older age range scored higher compared to the younger ones. This might have compromised the age correlations to appear significant. At the end of the program, that same participant had the lowest score (along with a notable evolution in all assessment measures), while the trend for older people scoring higher remained, so a correlation between age and psychological distress was found. Due to these facts, despite the small sample size, it seems plausible to hypothesize that

psychological distress may be more linked to the narrative that emerges in the OD process as well as to each of the internal and external resources available to overcome adverse experiences than only age per se. It leads to wonder about the factors of change in psychotherapeutic outcomes. These relations are dynamic and complex (Barber et al., 2001; Eilertsen & Eilertsen, 2023; Kazdin, 2009; Stulz et al., 2008), just as it is a psychotherapeutic process and human life, and consistent evidence in the literature is still scarce. Investing in the delivery of a relational and needs-adapted treatment seems to be something worth implementing to foster good therapeutic outcomes, but much is still to be unfolded. GAF scores improved statistically significantly from moderate to mild symptomology, which seems congruent with the above on the decrease of psychological distress, indicating less impairment at the level of psychological, social, and/or occupational functioning, which is expected to result in more aptness to meet quotidian demands. Also, higher levels of functioning (GAF) correlated positively with a superior educational level and employment/studying status. Literature shows that psychological distress is related to life impairment extended to several domains, including those related occupational and academic participation (Adler et al., 2006; Fergusson & Woodward, 2002; Gouveia et al., 2017; Gusmão et al., 2005; Hiilamo et al., 2019; Judd et al., 1996; Kessler et al., 1995; Lerner et al., 2004; Mauramo et al., 2019; McKnight & Kashdan, 2009; Murray & Lopez, 1997; Rothon et al., 2009; Wells et al., 1989). In addition, one of the participants who was on sick leave resumed work, and another one started a graduation as well as a peer-support program, which strengthens the findings of functioning improvement beyond metrics. Peer-support is recognized as an important facilitator of mental health recovery, showing benefits for peer workers, users, and mental health services. It shares a few common principles with open dialogue (Razzaque & Stockmann, 2016), and it has the potential to foster democratic values and disrupt clinical hierarchies within services (Bellingham et al., 2018). Therefore, involvement in other people's recovery processes is seen as a positive outcome enhanced by OD intervention. The family/social network (LSNS6) evolved positively in perceived support on the Friends dimension, shifting away from marginal ties evidence. Even so, the overall social support perception of the sample still claims additional attention due to the overall low scores, residual evolution, and absence of friends' involvement in OD meetings. This appears to be in line with findings related to family members as prime caregivers and often exclusively

social supporters for persons experiencing mental health issues (Albert et al., 1998; Brown & Birtwistle, 1998; Caqueo-Urízar et al., 2014; Gonçalves-Pereira, 2006; Ornelas, 1996; Palumbo et al., 2015; Poon & Lee, 2019; Saunders, 2003). Also, LSNS6 shows a tendency to correlate negatively with age and psychological distress, which seems consistent with literature findings in that as individuals grow older, social isolation and loneliness tend to increase (Dykstra et al., 2005; Grothe et al., 2022; Wrzus et al., 2013), adversely affecting both physical and mental health and raising the risk of mortality (Holt-Lunstad et al., 2015, 2017), even if it is still not clear whether psychological distress is the cause or consequence of lower social support and loneliness perceptions (Paúl & Ribeiro, 2008; Ribeiro et al., 2012; Routasalo et al., 2006; Villas-Boas et al., 2017).

In addition, a very strong negative correlation was found between the number of sessions attended and the end of program assessment for LSNS6. Also, evidence points to marital status as a significant predictor of OD meeting attendance, with it explaining about 58.9% of the attendance variance. Psychiatric prescriptions were kept, which might be explained by the pilot program's short duration. As important as clinical outcomes is user satisfaction. The OD program got a very positive rating, which might represent an advantage in terms of acceptability once it is acknowledged that service satisfaction is a crucial factor and a quality measure in the field of mental healthcare (Berghofer & Link, 2011; Ruggeri & Tansella, 2002; Sowers, 2005), just as it might explain part of the findings linked to the distress symptomatology decrease and the improvement in functioning due to the relation between user satisfaction and treatment adherence and consequent benefits (Druss et al., 1999; Priebe & Miglietta, 2019). Expected follow-up outcomes will provide more insights into OD long-term outcomes.

The marital status stood out in the findings. Although the tendency toward improvement has been global, those who were married reported at baseline an absence of friend's support and a decline in family support perception at the final, and overall, in both assessment periods, they had higher distress symptomatology, manifested more functioning impairment, were at risk of social isolation, and attended more meetings. Although the relationships found between marital status and the study outcomes are suggestive, inferences about marital status per se must be avoided. Beyond marital status, there were also a few common features, such as a similar diagnosis (depression),

both being in the older age group, being parents, struggling with conflicting familial relationships, domestic violence charges, and considering divorce. The literature on marital status varies. Being married seems to play a protective factor by positively influencing social contacts and support perception (Allen et al., 2000; Kislev, 2022; Pinquart, 2002, 2003; Theeke, 2010), by promoting emotional well-being (Brown, 2000; Ross et al., 1990; Simon, 2002), and by strengthening social networks and community involvement (Bryant et al., 2003). On the other side, lifelong challenges related to marital functioning and quality are also pointed out from a less favourable perspective for couples (Ayalon et al., 2013; Coyne et al., 2002; de Jong Gierveld et al., 2009; Kivelä, 1994; Umberson et al., 2005; Stevens & Westerhof, 2006), which can help make sense of the findings. In addition, factors related to background, problem acceptance, beliefs, and attitudes also play an important role in therapeutic engagement (Laranjeira et al., 2023), which will reflect in the commitment to overcome the crisis; thus, meeting attendance might also be predicted and explained by factors other than only marital status.

Regardless of socio-demographic, life background, clinical characterization, or other person-related singularity, it should be taken into account the importance of engaging in social activities, pro-social behaviours, and maintaining fulfilling interpersonal and family relationships as a protective factor against the challenges of ageing (Paúl, 2005), on mental and physical well-being improvement (Kim & Konrath, 2016; Lum & Lightfoot, 2005; Smith & Christakis, 2008; Trew & Alden, 2015; Valtorta et al., 2016), recovery, and reduction of the likelihood of relapses and hospitalization (Bucci et al., 2017; Casanova-Rodas et al., 2014; McFarlane et al., 2003; Norman et al., 2005; Pernice-Duca, 2010; Seikkula et al., 2001). It also promotes well-being and healthier family functioning (McFarlane et al., 2003; Hsiao et al., 2020) and alleviates distress during times of crisis (Rodin & Salovey, 1989). Thus, the OD approach is in line with this evidence and has been showing potential to over time facilitate collaborative relationships by assuming as crucial the network interactions in the dialogic process and their consequent transforming effect on the recovery process and relapse prevention (Bird et al., 2010; Claxton et al., 2017; Day & Petrakis, 2017; Griffith & Keane, 2018; Hawkes & Reed, 2015; Hinton et al., 2019; Johansen et. al, 2021; McFarlane 2016; McFarlane et al., 2003), and by promoting family learning on how to adapt and

preserve its integrity (Barrett & Linsley, 2017), therefore efforts must continue to be invested in this direction.

As limitations of this study, it is first underlined the very small sample size; therefore, a larger and more diverse sample would have been beneficial to the study's purpose, as it would reliably better elucidate the OD therapeutic effect. Additionally, the lack of randomization and comparison to other forms of treatment or control group clearly hinder the significance and generalizability of the findings. Until recently, there were no randomized controlled trials, which has been one of the main criticisms of OD's effectiveness. ODDESSI (Open Dialogue – Development and Evaluation of a Social Network Intervention for Severe Mental Illness) multi-site cluster randomized controlled trial (Pilling et al., 2022) comes to fill part of this gap. Even so, systematic research of every type in this field is still necessary to help with OD benefit exploration and its contribution to mental health, as well as to continue to assess acceptability and feasibility. The project's spread, participant accessibility and adherence, and meeting setting were undoubtedly affected by the COVID-19 confinements and associated challenges, just as there may have been an impact on clinical outcomes due to the documented worsening effects on the Portuguese population's mental health during the adversely mentioned context (ERS, 2023; INE, 2023). The short duration of the program and the fact that it was dependent on funding to operate, with the project being ended as funding ceases, also represent limitations with a direct impact on the psychological continuity principle, i.e., the responsibility to keep up with the care for as long as needed. In relation to measures, although CORE-OM and BSI are translated and adapted for Portugal, neither are validated nor report normative values. CORE-OM does not present a cut-off point for the Portuguese population, and Risk dimension has not reached an acceptable value for internal consistency, so future research is therefore required to bring more evidence to what concerns the psychometric properties of the scales. A longer version of LSNS (e.g., 18), which includes the neighbour’s subscale and a wider range of questions, could have been an advantage on social isolation screening, giving a more comprehensive view of the reality of the sample, though it is understandable that LSNS6 was chosen for being a validated, concise, and easily applied instrument. Additionally, it would be interesting to have had access to perceived health quality and well-being and their relation to LSNS outcomes, as perceived social isolation/loneliness

are often linked to health perceptions (Paúl & Ribeiro, 2008), just as to have had access to self-report perceived functioning impairment rather than a solely non-self-report measure as GAF, although CORE-OM dimensions cover some functioning-related items. The satisfaction with family/extrafamiliar relationships was not assessed post-intervention, and due to the high initial dissatisfaction expression, it seems relevant to access participants' and families' perspectives on this matter after the OD therapeutic process. A broader satisfaction questionnaire would have been a plus to gain a deeper comprehension of the user experience. Clinical team satisfaction was not assessed.

Overall, while considering the present study into account, the limited findings match previous OD literature findings and confirm promising outcomes. Finally, it clarifies the urgency of further research to support this comprehensive intervention. Therefore, this work might be an elucidating drop in the ocean of evidence-based practice and strengthen the Open Dialogue approach.

FINAL CONSIDERATIONS

Open Dialogue, an approach grounded in human rights principles (WHO, 2021a), has been showing evidence to commit and fulfil the requirements of a community-oriented care system and recovery (Thornicrof et al., 2016) and effectively support families and involve them actively in mental health treatments. Considering this supportive background, OD clearly meets the criteria to be considered an effective form of care, and its contribution certainly may be an added value for the Portuguese mental health system and its recipients.

Despite some worrying facts on mental health matters in Portugal and decades of underinvestment in what is recognized as a worldwide problem (WHO, 2021a), efforts have been put in over the years to improve the functioning of the National Health Service. As far as it is known, a promising mental health reform is on the move, greatly supported by Europe Union Recovery and Resilience Plan funds, with a very significant investment volume, of unprecedented expression, announced as able to provide the country with timely, outreach, equity, and quality mental health care. Along with other relevant planning actions announced, it is chosen to highlight here the creation of about 40 community teams whose aim is to perform outreach work to the population, which conceptually is aligned with the fundamental transformation needed within the mental health sector (WHO, 2021a), which involves a reassessment of policies, laws, systems, and services to deliver a positive impact on individuals and communities. Therefore, it is of utmost importance to guarantee that every intervention is carefully designed to effectively meet the person's needs and be genuinely support-centred. This entails incorporating principles such as voluntary participation, shared decision-making, peer support, and community-oriented approaches (WHO, 2021a). It appears, certainly to OD supporters, an exceptional chance to invest in this mental health care approach as part of the national services portfolio.

Concerning anticipated challenges to implementation, what stands out first from literature is that OD cannot be implemented instantly; it may require a substantial restructuring of the mental health care system and calls for a whole team that not only values this kind of approach and has a high level of commitment and resilience but is also granted access to time, resources, and funding to fully operate. Training and supervision play a central role (Alanen, 2009; Eassom et al., 2014),

since this kind of health care presupposes the psychotherapeutic skills and experience of team members in working with people in crisis and their families (Seikkula et al., 2003), but team expertise is meant to be primarily focused on generating dialogue and the equal exchange of perspectives (Olson et al., 2014). In addition, it will require strong leadership, a supportive organizational culture, and a true shift in professional roles and identities as well as in attitudes towards viewing the family as equal partners; otherwise, there is a risk of continuing to deliver a service based on individualistic and biological models where actions are unilaterally decided rather than emerging from a joint process. It is often hard to acknowledge, for both professionals and users, that the truest healing element is simply to be heard, to have a response, and that when the response is given and received, the therapeutic work is fulfilled (Seikkula & Trimble, 2005). In this way, the dialogical approach can, through its potential, assist in exploring common concerns about privacy, power relations, and fear of negative outcomes, as well as in restructuring beliefs on authority, expectations of being informed about what to do, and the need for an exclusive user-professional relationship (Eassom et al., 2014). The greatest challenge looks more like how to become dialogical (Seikkula, 2011).

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APPENDICES

Appendix A

Literature review

Open Dialogue (OD) is a non-hierarchical system of service organization and mental health treatment that originated in the 1980s in Tornio, within the Finnish Keropudas hospital, an hospital originally intended for psychiatric chronic illness and gradually redesigned for psychiatric acute care, from the team's desire to change the method of acute psychiatric crisis management in which they worked to a more humanistic and democratic perspective, also family-centered. The OD approach framework fits into social constructivism, integrating different psychotherapeutic traditions, which will be succinctly described in this section, whose purpose is to promote therapeutic effects from dialogicity due to its potential to produce new views, new narratives, and new meanings co-produced by language. The OD does not settle on a phenomenon explanation but instead explores the way in which a particular family faces a problematic situation, working jointly on the exploration of new resources to deal with the adverse situation. The team, which started to perform family therapy (Selvini-Palazzoli et al., 1978), strived to ensure that, before any decision related to treatment and/or hospitalization, both the person identified as in crisis and his/her family and/or support network, as well as the technicians involved in the case, would be called to a meeting whose purpose would be to act in an open and transparent way during the whole process of planning and decision-making that, ideally, would be joint. From this will, it evolved into what Seikkula et al. (1995) called Open Dialogue, gradually covering not only the psychiatric inpatient unit but crossing the barrier of the hospital walls to a continuum of services in the community, but not without facing at first a few challenges to the therapeutic approach's acceptance.

The Systemic Family Model (Selvini-Palazzoli et al., 1978), also known as the Milan Model, is a therapeutic model inspired by the Batesian "double bind" concept, whose model's contribution to clinical practice was, at the time, recognized as the most significant (Hoffman, 1981, cited in Seikulla & Olson, 2003) by using a communication approach in the treatment of psychoses along with techniques to untangle paradoxical communication (counter-paradox). Despite its initial popularity, low evidence of long-term outcomes was found, and gradually other

approaches were implemented, mainly psychoeducational family approaches. The communication approaches' to psychosis treatment started to get relevant by the time Bateson and colleagues presented a theory of schizophrenia based upon communication (Bateson et al., 1956), whose emphasis was on the larger system of relations, which gave rise to the "double-bind" concept, a communication dilemma that comes from a permanent conflict between messages that caught people up in an ongoing system that produces conflicting definitions of the relationship and consequent subjective distress, then more likely to schizophrenic symptoms emergence. It was the starting point for family therapy.

OD derives from Yrjö Alanen's "need-adapted" treatment (1997; 2009), whose main interests have been the psychodynamic study of schizophrenic psychoses and individual and family psychotherapy, which approach inspired the Keropudas team in the moment they were dealing with low rates of family engagement. The "need-adapted" treatment, which will be briefly described below, oriented the Keropudas team in the sense that, initially, even starting with family therapy, they still maintained part of the traditional process of users' admission, i.e., an anamnesis, a psychological evaluation, contact with the nursing team, and, finally, a team meeting for therapeutic plan formulation. During this process, the person in crisis contacts different technicians alone, while staff meet afterward without his/her presence. The team quickly realized that the model they were adopting, in fact, was not aligned with what they had initially conceived. Among other relevant factors, the perception of a distant and objectifying view of the family, being here positioned as an object of therapeutic action rather than as a partner in the therapeutic process, was decisive in encouraging the team to look for solutions, although they also recognized qualities of the model that were found useful in their clinical practice (Seikkula & Olson, 2003). The turning point was the introduction of open meetings, as implemented by Yrjö Alanen in the also Finnish psychiatric hospital in Turku, whose aim was to include from the beginning not only the person in crisis admitted to the hospital but relatives and technicians too, which replaced the traditional procedures and family therapy in a non-joint format with a more open and integrative form of care. From this day on, the team decided to reorganize the way admissions were handled and no longer perform individual appointments but lead a joint process where everyone has an active role, which led to much more positive results and encouraged them to continue with the work.

"Need-adapted", a humanistic, comprehensive, and psychotherapeutically oriented treatment (Alanen, 2009), emphasizes the importance of understanding the unique needs and experiences of people with diagnoses of psychoses classified as the "schizophrenia group", clinically and prognostically very heterogeneous, in order to provide an effective and personalized treatment. Instead of following the traditional model, the one based on criteria agreed on by convention and with vague diagnostic boundaries, whose main (if not only) way of treatment is neuroleptic medicines and, here, seen as often overlooking the subjective experiences and social context of people diagnosed with schizophrenia, the "need-adapted" approach proposes, as the name suggests, to consider a person in crisis's specific needs through a shared empathic attitude, open communication, frequent open group activities, and meetings. Surprisingly, it was found that specialized psychiatric nurses, who work on the ward and become profoundly familiar with the users' problems, constituted a therapeutic resource that was, by that time, scarcely used. They realized that it was crucial to start working with families, especially in cases where such work was clearly needed, so the team began to perform therapy meetings with newly admitted users and their relatives or close people. The "need-adapted" approach does not go against the use of neuroleptics when extremely needed and as a complement to psychotherapeutic treatment and recognizes that small doses can sometimes be helpful; however, it clearly opposes the dominant treatment paradigm of schizophrenia group psychoses, with neuroleptic medicines being considered as first-line treatment (Cooper et al., 2020; Pavlovic et al., 2016). OD also seeks to avoid starting the use of neuroleptic medicine during the early stages of treatment, postponing it as much as possible.

The central elements established during the early development of this approach, which was initially designed to meet the needs of schizophrenia group psychoses treatment and was mainly oriented for family-centered therapy but has nowadays also been applied to other cases of extreme psychological distress, were: 1) Flexible therapeutic activities: to meet the real, changing needs of both users and those in the network, which was found to be usually the family; 2) Psychotherapeutic attitude: both in the examination and treatment approach; 3) Complementary therapeutic activities; 4) Continuing process and 5) Follow-up. With this, the team aimed to turn their psychosis ward into a psychotherapeutic community while promoting recovery and empowerment in a supportive and non-stigmatizing environment by fostering a sense of autonomy, self-determination, and social

integration. This approach often helped to quickly alleviate, or even eliminate, the symptoms of acute crises. Despite the family-centered work approach, individual therapies are still conducted when appropriate. Further, there is evidence that this therapeutic practice of family integration attracted and retained users who lacked the motivation for individual therapy and that successful individual therapy was often promoted by family integration in the preceding therapy meetings. The "need-adapted" treatment became a success and was gradually adopted in several parts of Finland, with the Western Lapland Project (OD) recognized as one of the most significant and successful adaptations (Alanen, 2009).

Due to its significant contributions to the field of dialogue and language, emphasizing its crucial role in human development and social interaction, dialogical principles such as "polyphony" (Bakhtin's, 1984) as well as "Zone of Proximal Development" and "Scaffolding" (Vygotsky, 1970) had both an important role in assisting to better understand phenomena that the Keropudas team saw arising as a result of their new practice, just as Andersen's (1991) "reflecting team" concept became equally significant in the further development of what is now OD, nowadays a well-structured approach.

An adequate OD practice involves being able to listen and adapt to the context and language of each exchange. It is the interaction between the group of participants involved in an inevitably idiosyncratic therapeutic dialogue that offers the possibilities for positive change. It is characterized by the commitment to an immediate response from the first psychiatric crisis and the use of dialogic and networked approaches in meetings — the key unifying and collaborative moment — with the purpose of fostering a community spirit and ensuring that those involved in the process feel heard and validated (Olson et al., 2014). This practice favors low medicines use, a systemic vision, shared decision-making, and dialogue as a starting point for effective problem solving (Aaltonen et al., 2011; Seikkula et al., 2011). From the experiences of developing the OD and research works over the years, it was possible to gather 7 principles (Seikkula & Arnkil, 2014), whose aim is to optimize the treatment process, of which 5 are of an "organizational" feature and 2 are of a "practical" feature (Tolerance to uncertainty and Dialogicity and polyphony), as follows: 1) Immediate help: the team strives to set up a 24-hour crisis service and arrange the first meeting within 24 hours of the first contact by the person at the centre of concern, a relative, or a referral entity. One aim of the

immediate response principle is to prevent hospitalization in as many cases as possible. With the person at the centre of concern participating in the very first meetings, the greater the chances are for the expression of disturbing content that, during a crisis, may come up and, otherwise, might not be expressed. It started to become clearer then that the shorter the duration of untreated symptoms, the higher the chances of a better prognosis (Birchwood et al., 1997, 1998; Lieberman et al., 2001; Seikkula et al., 2001); 2) A social network perspective: the person at the centre of concern, his/her family, and/or other key members of the social network who recognize the crisis faced as a problem are always invited to the meetings with the aim of mobilizing support for both the person at the centre of concern and his/her family. The decision-making process for who participates in the therapeutic meetings is joint, starting with the team consulting the person who made the first contact about who might be the other people concerned, who could be helpful, and who would be the best person to proceed with the invitations. The moment when the crisis is overcome is considered when those involved and who evaluated the situation as problematic no longer see it that way; 3) Flexibility and mobility: these principles are guaranteed by adapting the treatment response to the specific and often changing needs of each case. The treatment meetings are, ideally, organized at the person at the centre of concern's home, and, initially, daily meetings may be necessary. Since it is expected that throughout the process the therapeutic proposals will vary according to needs, it is not outlined in advance a time and/or frequency plan; instead, in each meeting it is defined when the next meeting will take place. This may occur the next day, a week later, or next month; 4) Responsibility: whoever (from the crisis team) received the first demand is responsible for organizing the first meeting and, when necessary, identifying other colleagues who could help. The OD approach foresees the definition of direct responsibility for services as a fundamental step so that the person in crisis and his/her relatives do not have difficulties accessing treatment when needed. Also, resources must be available to enable a quick response, and mobile crisis teams seem to facilitate mental health care in this sense (in the first 5 years, the OD approach was performed only through home visits, which reorganized the system as the need for hospitalization dropped); 5) Psychological continuity: since it is known that referring cases to other services is often a cause of treatment discontinuity and difficult for the therapeutic bond and recovery, the team takes responsibility for treatment for as long as needed, both in the outpatient

and inpatient settings. The OD approach does not compete with other modalities of care, so in the event of a need for other therapeutic services, the team will see them as complementary and strive to mobilize resources to guarantee the more appropriate service; 6) Tolerance of uncertainty: one of the key aspects at the beginning of a crisis care process is the team's ability to ensure safety and trust perception, so uncertainties can be better handled. In the early stages of a crisis, the team strives to make it possible to emerge a shared language about a difficult experience, avoiding early decisions, explanations, and interpretations of what is going on since it is expected that new meanings may be constructed together and, consequently, needs can be adjusted. The OD approach emphasizes that during the first moments of crisis, there is a window of access to contents that would hardly manifest themselves at other times, so there is an opportunity for mobilization of the psychic resources necessary for the recovery of the person in crisis. Medication can hinder or even prevent the person from accessing important resources for the elaboration, which is why it should preferably not be prescribed in the first meetings; instead, it should be discussed in at least three meetings before a decision; 7) Dialogicity: the focus is primarily on promoting dialogue, not on changing the person at the centre of concern and/or his/her family. Dialogue is seen as a way through which families and the person in crisis can acquire more agency in their own lives by discussing problems while building new understandings and making it possible for everyone to feel welcome to speak as well as for the team to openly reflect on their perceptions in the presence of everyone. Good outcomes are more likely to arise when there is significant topic permanence in the dialogue, the presence of symbolic language, and mastery of the intervention by the person at the centre of concern and his/her respective social network, which emphasize the effectiveness of genuine dialogic intervention compared to monologic communication (Seikkula, 2002).

From this set of principles, 12 key elements were established (Olson et al., 2014) to ensure the fidelity of dialogical practice and guide its implementation, whereby Tolerance to uncertainty and Dialogicity and polyphony are necessarily interconnected in the characterization of these 12 elements due to their importance in the therapeutic encounter. Although there are no clear guidelines on how to facilitate a psychotherapeutic session using OD, since the intention is to suspend pre-established hypotheses and typified interventions, directivity is then an element opposed to what is intended to flow in this type of process. However, this does not mean that there

are not recommended elements and actions that essentially aim at seeking to benefit the fluidity of the dialogue and the mobilization of the resources of the network in participation and therefore should be ensured: 1) Two (or more) technicians in the team meeting: since teamwork is recognized as essential for effective action in the area of severe, acute, and chronic psychiatric crises; 2) Participation of the family and/or network: the involvement that is expected to be achieved, due to its recognized importance in the process, begins to be worked out right from the initial request for help, so it is common to start with an exploration about who might be concerned about the person identified as in crisis and/or aware of the problematic experience. Although the presence of others is recommended, it is not always possible and/or desirable (e.g., violence, abuse), so it is not an imposed condition, and non-joint sessions can occur if it makes sense; 3) Use of open questions: from this type of question, it was tried to develop a process as collaborative as possible ("What is the history of the idea of the meeting?/How would you like to use this meeting?"), and this practice promotes that everyone is heard (if they wish), that a neutral choice of content may be made, and that a reflective voice may be exercised, i.e., that there is implicit in the dialogue a rationale associated with the request for help and respective expectations, as well as making it possible to become aware of potential participants who are not present and who may collaborate for the process.; 4) Respond to the client's statements: this response takes three possible forms, and its intention is to trigger another response, i.e., to stimulate the continuity of the dialogue. It is suggested to a) use the client's own words (follow the client's words and then integrate them); b) adopt responsive listening (this practice naturally derives from the previous one; it is recognized that responsive listening enhances a safe environment for intimate sharing and better support in exploring concerns); and c) maintain nonverbal attunements, including silences (nonverbal communication is as important as speech, so one should allow and seek to tolerate silences, as well as monitor all expressions of communication, e.g., facial expressions, rate of breathing, changes in rate of voice, unexpected departure from the meeting space, etc.); 5) Emphasize the present moment: this emphasis is given by a) responding to the immediate reactions that take place during the meetings (not leaving, for example, only for the record and trying to provide the opportunity for any clarification that is felt to be necessary) and b) allowing for the emotions that are triggered (creating a safe space for these, but without early interpretations); 6) Evoking multiple points of

view (polyphony): more than seeking consensus, the OD seeks to promote, even if there are tensions, the most varied points of view, where a) external polyphony represents the involvement of all those present in the dialogue, in which it is important to develop sensitivity to allow all voices to be heard and respected, and b) internal polyphony, in which each element is encouraged to talk about their point of view and experiences in a more complex way; 7) Use of relational focus in the dialogue: the identified problems are approached from a relational perspective, so that by asking questions in a circular form, it is tried to establish a dialogue that includes more than one person, define the family/network relationship, and explore the adjacent relational to the identified difficulties, always with the purpose of making such relations better defined and differentiated, keeping this practice flowing according to the opportunities that arise during the dialog (never pre-defined, which would be considered monologic for its imposition character) and that allow the exploration of new paths; 8) Respond to the problem's behavior and speech as significant: it is sought to explore and validate, in a subtle and collaborative way, the contours of the speech and/or behavior of each one involved, not through a look that pathologizes but that faces the expressions that emerge with a meaning, often not yet grasped, as well as natural in the face of the singular experience of each one; 9) Emphasize the clients' own words and stories, not the symptoms: the dialogical practice promotes the experiential narrative of feelings and thoughts, so that the capture of a certain phrase, or even a simple word, may result in associations of extreme importance for a therapeutic process, which allows the understanding of symptoms as a possible incorporation of an inexpressible experience, commonly associated with traumatic experiences and with a tendency to resist common language, often revealing itself through small details; 10) Conversation between professionals (reflections) in treatment meetings: this reflective process between meeting facilitators should be emphasized as a crucial moment of the meeting and enhancer of transformation, where both professionals, in the course of the continuous flow of the meeting, "turn" to themselves and explore, based on what has been brought by the person in crisis and his/her network, reflections about what has resonated in them and possible treatment directions. The reflecting process, i.e., the act of listening and talking jargon-free and speculatively based on the themes introduced by the clients — speaking as listener and not as author — (Lyotard, cit in Olson et al., 2014) represents a huge chance for both the person in the centre of concern and his/her family

to reconstrue their experience (Andersen, 1995). Subsequently, there are moments reserved for the client and the present support network, in which space is made for them to have a voice about the future through the exposure of their perceptions and thoughts about the reflections and associations previously exposed by the facilitators; 11) To be transparent: all involved share the same level of information and decision-making, and as previously informed, even if there is an initial reflective moment between professionals, this precedes a moment in which the voice of the person and his/her support network is given priority and in which possibilities of treatment are explored together, with no room for the imposition of experts. The act of reflecting together implicitly has this key element, which is transparency; and 12) Tolerate uncertainty: besides being a key element, it is also one of the 7 basic principles of OD, recognized as an essential part of the dialogue, which propose that there is room for a joint organic understanding (polyphony) of the problematic and a change in the professional's behavior, moving away from the habit of quick interpretations and directive instructions, favoring the legitimacy of the active participation of each participant, so that, gradually, a relationship of security is established, which will promote a better tolerance of the uncertainty present in moments of crisis. This uncertainty is expressed with greater intensity in some professionals not so accustomed to OD practice, since it is not a process with strictly defined steps, with imposed "truths", and easily controlled by the expert, but rather promotes other points of view, including, obviously, those of professionals, although with openness for them to be also commented on and even questioned.

The interest in OD has been gradually increasing over the last three decades (Buus et al., 2017, 2021; Cooper et al., 2020; Freeman et al., 2018; Gomis et al., 2017; Kantorski & Cardano, 2019; Kłapciński et al., 2015; Lakeman, 2014; Pavlovic et al., 2016; Pilling et al., 2022). The evidence, in both short and long-term outcomes, shows a tendency to strengthen the OD approach, mainly in what concerns to higher rates of employability and academic participation (Alakare and Seikkula, 2022; Aaltonen et al., 2011; Gordon et al., 2016; Seikkula et al., 2003, 2006, 2011), reduction of psychiatric symptomatology (Cotes et al., 2023; Gordon et al., 2016; Seikkula et al., 2003), lower rates of relapses (Seikuula et al., 2003; Seikkula et al., 2011), of suicidal ideation (Granö et al., 2016), of hospital admissions (Aaltonen et al., 2011; Bergström, et al., 2017; 2018; Seikuula et al., 2003; Tuori et al., 1998), of use of neuroleptic medication, and allocation of

disability and unemployment benefits (Alakare & Seikkula, 2022; Bergström, et al., 2018; Lehtinen et al., 2000), which in general is expressed into an overall improvement in life functioning (Gordon et al., 2016; Seikkula et al., 2003).

OD positive effects go beyond clinical outcomes (but are equally important), with findings, citing a few, showing that the approach was effective in eliminating waiting lists for outpatient psychiatric services (Jensen & Jensen, 2001) and in promoting better coordination between social and healthcare services (Balleby & Søbjerg, 2012; Søbjerg & Balleby, 2012). OD improved trust in the care provided (Rosen & Stoklosa, 2016), enhanced communication and relationships with mental health staff, developed shared understandings of mental health (Twamley, 2020), and made people feel safe, seen, heard, cared for, and respected (Balleby & Søbjerg, 2012; Dawson et al., 2021; Gidugu et al., 2021; Søbjerg & Balleby, 2012). Participants and family members appreciated having time for meetings, the openness, and the transparency, not just medication-focused, and felt part of decision-making (Florence et al., 2021; Gidugu et al., 2021; Gordon et al., 2016; Hendy & Pearson, 2020). The network approach resulted in a positive impact on the number and quality of family relationships (Thylstrup, 2009), was seen as an important part of the treatment (Bergström et al., 2022), gave participants better insight, and strengthened their ability to cope with mental health problems (Brottveit, 2002). It was found to be helpful to reduce stigma, validate concerns, access multiple perspectives, facilitate shared decision-making, assist in creating language to describe conflict and interpersonal relationships (Florence et al., 2021), and initiate the development of new roles in the family (Sættem, 2008). Home visits were a positive aspect of the approach (Seikkula et al., 2006). OD gave staff members more opportunities to respond authentically (Buus et al., 2021) and positively impacted their clinical work, relationships with users, families, and colleagues (Florence et al., 2020). Staff satisfaction was high (Gordon et al., 2016), they believed that OD had improved their professional attitude (Nielsen, 2011), and demonstrated consensus at the level of beliefs about the importance of the key principles of OD (Razzaque & Wood, 2015; Seikkula et al., 2011).

As is inherent in any field, OD also faces challenges to implementation and acceptance, such as conflicting perspectives, difficulty maintaining interest, the need for committed and involved leaders (Jacobsen et al., 2023), poor management of staff (Lian, 2006), costly and lengthy

training, resistance to shifting organizational culture (Florence et al., 2020), and the particular financial management structures to implement network meetings (Johansen & Weber, 2007). Staff found it challenging to adapt the expert role (Brottveit, 2002; Johansen & Weber, 2007) and to collaborate with professionals from other disciplines, and occasionally felt inadequate providing OD (Thylstrup, 2009). Also been noticed different levels of motivation and understanding regarding role transformation processes as well as issues of power and hierarchy (Holmesland et al., 2010). Staff had some concerns about recruiting sufficiently trained Open Dialogue therapists and coordinating the network meetings (Balleby & Søbjerg, 2012; Søbjerg & Balleby, 2012), scheduling urgent meetings while managing their other cases (Gordon et al., 2016), and felt that meetings were personally challenging because of high levels of uncertainty and disclosure (Sjømæling, 2012). A few studies also reported a small number of instances where clients and families/social network members expressed a preference for more conventional services, including expert advice (Buus et al., 2021), mixed experiences regarding family involvement and immediate home visits (Bergström et al., 2022) and clients who struggled with unusual practices of reflection and non-directive meetings (Tribe et al., 2019).

Appendix B

Table 1

Socio-demographic characterization

	Total (n=7)					
	N	**%**	**M**	**SD**	**Min**	**Max**
Age	7	100	38,14	15,25	14	62
Sex						
Female	5	71,40				
Male	2	28,60				
Education level						
Until high school	5	71,40				
At least undergraduate	2	28,60				
Professional situation						
Employed	2	28,60				
Studying	2	28,60				
Sick leave	1	14,30				
Disability allowance	1	14,30				
Retired	1	14,30				
Marital status						
Single	5	71,40				
Married	2	28,60				
Residential context						
Home of parents/relatives	4	57,10				
Owned/rented private home	3	42,90				

Note. M – Mean; SD – Standard deviation; Min – Lowest observation; Max – Highest observation

Appendix C

Table 2

Clinical characterization

Total (n=7)	**Before program**	
	N	**%**
Hospitalization		
Yes	1	14.30
No	6	85.70
Self-harm		
Yes	1	14.30
No	6	85.70
Suicide attempt		
Yes	3	42.90
No	4	57.10
Residential context satisfaction		
Very unsatisfied	1	14.30
Moderately dissatisfied	3	42.90
Moderately satisfied	3	42.90
Extrafamilial relationship satisfaction		
Yes	1	14.30
No	6	85.70
Medicines use before program		
Yes	6	85.70
No	1	14.30

Appendix D

Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)

CORE-OM

Identif. Serviço:

Idade: Género: M F

Identif. Caso:

Identif. Terapeuta

Data de preenchimento

D D M M A A A A

Fase de preenchimento

T Triagem
E Encaminhamento
A Avaliação pré-tratamento
P Pré-primeira sessão
1 Pré-terapia, não especificado
D Durante Terapia
U Última sessão
X Follow up 1
Y Follow up 2

Fase

Episódio

IMPORTANTE – LEIA ANTES DE RESPONDER

Este questionário tem 34 afirmações sobre como se sentiu durante a última semana. Por favor, leia cada afirmação e pense quantas vezes se sentiu assim. Depois, marque a resposta que mais se aproxima da maneira como se sentiu.

Durante a última semana...	Nunca	Raramente	Às vezes	Muitas vezes	Sempre, ou quase sempre	Em branco, não preencher	
1 Tenho-me sentido terrivelmente sozinho/a e isolado/a	0	1	2	3	4		F
2 Tenho-me sentido tenso/a, ansioso/a ou nervoso/a	0	1	2	3	4		P
3 Senti que tenho alguém a quem posso pedir ajuda, se precisar	4	3	2	1	0		F
4 Tenho-me sentido bem comigo próprio/a	4	3	2	1	0		W
5 Senti-me totalmente sem energia ou entusiasmo	0	1	2	3	4		P
6 Fui violento/a fisicamente com outras pessoas	0	1	2	3	4		R
7 Tenho sentido que sou capaz de lidar com as coisas que correrm mal	4	3	2	1	0		F
8 Tenho-me sentido incomodado/a com dores, mal-estar ou outros problemas físicos	0	1	2	3	4		P
9 Pensei em fazer mal a mim próprio/a	0	1	2	3	4		R
10 Tem-me custado muito falar com as outras pessoas	0	1	2	3	4		F
11 A tensão e a ansiedade não me têm deixado fazer coisas importantes	0	1	2	3	4		P
12 Senti-me bem com as coisas que consegui fazer	4	3	2	1	0		F
13 Tenho tido pensamentos e sentimentos que não quero ter e que me perturbam	0	1	2	3	4		P
14 Tenho sentido vontade de chorar	0	1	2	3	4		W

Vire a página, por favor

por

Página 1

Durante a última semana...

		Nunca	Raramente	Às vezes	Muitas vezes	Sempre, ou quase sempre	Não estou certo/a/ Não pretendo	
15	Senti pânico ou terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
16	Fiz planos para acabar com a minha vida	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	R
17	Senti que os meus problemas são demais para mim	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	W
18	Tenho tido dificuldade em adormecer ou em dormir toda a noite	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
19	Senti que tenho pessoas de quem gosto	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐	F
20	Não consegui pôr os meus problemas de lado	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
21	Tenho sido capaz de fazer a maior parte das coisas que preciso	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐	F
22	Ameacei ou fiz alguém sentir medo	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	R
23	Senti-me desesperado/a ou sem saída	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
24	Pensei que era melhor se eu estivesse morto/a	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	R
25	Tenho-me sentido criticado/a por outras pessoas	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	F
26	Senti que não tinha amigos	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	F
27	Tenho-me sentido triste	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
28	Tenho-me sentido perturbado/a por imagens ou recordações que não quero ter	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
29	Tenho-me sentido mais facilmente irritável quando estou com outras pessoas	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	F
30	Tenho-me sentido culpado/a pelos meus problemas	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	P
31	Tenho-me sentido optimista em relação ao meu futuro	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐	W
32	Tenho conseguido as coisas que queria	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐	F
33	Senti-me humilhado/a ou envergonhado/a por outras pessoas	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	F
34	Fiz mal a mim próprio/a fisicamente, ou pus a minha saúde gravemente em risco	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	R

OBRIGADO PELA SUA COLABORAÇÃO

TOTAIS

RESULTADOS MÉDIOS

total de cada dimensão a dividir pelo número de itens respondidos nessa dimensão

(W)	(P)	(F)	(R)	Todos os itens	Todos menos R

Appendix E

Brief Symptom Inventory (BSI)

BSI

L.R. Derogatis, 1993; Versão: M.C. Canavarro, 1995

A seguir encontra-se uma lista de problemas ou sintomas que por vezes as pessoas apresentam. Assinale, num dos espaços à direita de cada sintoma, aquele que melhor descreve o GRAU EM QUE CADA PROBLEMA O INCOMODOU DURANTE A ÚLTIMA SEMANA. Para cada problema ou sintoma marque apenas um espaço com uma cruz. Não deixe nenhuma pergunta por responder.

Em que medida foi incomodado pelos seguintes sintomas:	**Nunca**	**Poucas vezes**	**Algumas vezes**	**Muitas vezes**	**Muitíssimas vezes**
1. Nervosismo ou tensão interior	☐	☐	☐	☐	☐
2. Desmaios ou tonturas	☐	☐	☐	☐	☐
3. Ter a impressão que as outras pessoas podem controlar os seus pensamentos	☐	☐	☐	☐	☐
4. Ter a ideia que os outros são culpados pela maioria dos seus problemas	☐	☐	☐	☐	☐
5. Dificuldade em se lembrar de coisas passadas ou recentes	☐	☐	☐	☐	☐
6. Aborrecer-se ou irritar-se facilmente	☐	☐	☐	☐	☐
7. Dores sobre o coração ou no peito	☐	☐	☐	☐	☐
8. Medo na rua ou praças públicas	☐	☐	☐	☐	☐
9. Pensamentos de acabar com a vida	☐	☐	☐	☐	☐
10. Sentir que não pode confiar na maioria das pessoas	☐	☐	☐	☐	☐
11. Perder o apetite	☐	☐	☐	☐	☐
12. Ter um medo súbito sem razão para isso	☐	☐	☐	☐	☐
13. Ter impulsos que não se podem controlar	☐	☐	☐	☐	☐
14. Sentir-se sozinho mesmo quando está com mais pessoas	☐	☐	☐	☐	☐
15. Dificuldade em fazer qualquer trabalho	☐	☐	☐	☐	☐
16. Sentir-se sozinho	☐	☐	☐	☐	☐
17. Sentir-se triste	☐	☐	☐	☐	☐
18. Não ter interesse por nada	☐	☐	☐	☐	☐
19. Sentir-se atemorizado	☐	☐	☐	☐	☐
20. Sentir-se facilmente ofendido nos seus sentimentos	☐	☐	☐	☐	☐
21. Sentir que as outras pessoas não são amigas ou não gostam de si	☐	☐	☐	☐	☐
22. Sentir-se inferior aos outros	☐	☐	☐	☐	☐
23. Vontade de vomitar ou mal-estar do estômago	☐	☐	☐	☐	☐
24. Impressão de que os outros o costumam observar ou falar de si	☐	☐	☐	☐	☐
25. Dificuldade em adormecer	☐	☐	☐	☐	☐
26. Sentir necessidade de verificar várias vezes o que faz	☐	☐	☐	☐	☐

Em que medida foi incomodado pelos seguintes sintomas:	Nunca	Poucas vezes	Algumas vezes	Muitas vezes	Muitíssimas vezes
27. Dificuldade em tomar decisões	☐	☐	☐	☐	☐
28. Medo de viajar de autocarro, de comboio ou de metro	☐	☐	☐	☐	☐
29. Sensação de que lhe falta o ar	☐	☐	☐	☐	☐
30. Calafrios ou afrontamentos	☐	☐	☐	☐	☐
31. Ter de evitar certas coisas, lugares ou actividades por lhe causarem medo	☐	☐	☐	☐	☐
32. Sensação de vazio na cabeça	☐	☐	☐	☐	☐
33. Sensação de anestesia (encortiçamento ou formigueiro) no corpo	☐	☐	☐	☐	☐
34. Ter a ideia que deveria ser castigado pelos seus pecados	☐	☐	☐	☐	☐
35. Sentir-se sem esperança perante o futuro	☐	☐	☐	☐	☐
36. Ter dificuldade em se concentrar	☐	☐	☐	☐	☐
37. Falta de forças em partes do corpo	☐	☐	☐	☐	☐
38. Sentir-se em estado de tensão ou aflição	☐	☐	☐	☐	☐
39. Pensamentos sobre a morte ou que vai morrer	☐	☐	☐	☐	☐
40. Ter impulsos de bater, ofender ou ferir alguém	☐	☐	☐	☐	☐
41. Ter vontade de destruir ou partir coisas	☐	☐	☐	☐	☐
42. Sentir-se embaraçado junto de outras pessoas	☐	☐	☐	☐	☐
43. Sentir-se mal no meio das multidões como lojas, cinemas ou assembleias	☐	☐	☐	☐	☐
44. Grande dificuldade em sentir-se "próximo" de outra pessoa	☐	☐	☐	☐	☐
45. Ter ataques de terror ou pânico	☐	☐	☐	☐	☐
46. Entrar facilmente em discussão	☐	☐	☐	☐	☐
47. Sentir-se nervoso quando tem que ficar sozinho	☐	☐	☐	☐	☐
48. Sentir que as outras pessoas não dão o devido valor ao seu trabalho ou às suas capacidades	☐	☐	☐	☐	☐
49. Sentir-se tão desassossegado que não consegue manter-se sentado quieto	☐	☐	☐	☐	☐
50. Sentir que não tem valor	☐	☐	☐	☐	☐
51. A impressão de que, se deixasse, as outras pessoas se aproveitariam de si	☐	☐	☐	☐	☐
52. Ter sentimentos de culpa	☐	☐	☐	☐	☐
53. Ter a impressão de que alguma coisa não regula bem na sua cabeça	☐	☐	☐	☐	☐

Appendix F

Global Assessment of Functioning (GAF)

ESCALA DE AVALIAÇÃO GLOBAL DE FUNCIONAMENTO (AGF)

Considerar o funcionamento psicológico, social e ocupacional como fazendo parte de um continuum hipotético de saúde-doenças mentais. Não incluir a deficiência do funcionamento devida a limitações físicas (ou ambientais).

Funcionamento superior num largo espectro de atividades, os problemas da vida nunca parecem ficar sem solução, é procurado por outros devido às suas muitas qualidades positivas. Ausência de sintomatologia.	100----------91
Ausência ou sintomatologia mínima (por exemplo, ansiedade ligeira antes de um exame), bom funcionamento em todas as áreas, interesse e envolvimento num espectro alargado de atividades, eficaz socialmente, de uma maneira geral satisfeito com a vida, os problemas e as preocupações não ultrapassam os do dia-a-dia (por exemplo, discussão ocasional com familiares).	90----------81
Se estiverem presentes sintomas, estes representam rações transitórias e esperadas a fatores de estresse psicossocial (por exemplo, dificuldades em concentrar-se depois de uma discussão familiar); apenas uma ligeira deficiência do funcionamento social, ocupacional ou escolar (por exemplo, atraso temporário no rendimento escolar).	80----------71
Alguma sintomatologia leve (por exemplo, humor deprimido e insônia leve) OU alguma dificuldade no funcionamento social, ocupacional ou escolar (por exemplo, ociosidade ocasional ou furto no seio familiar), mas bastante bom no funcionamento de uma maneira geral, alguasm relações interpessoais significativas.	70----------61
Sintomatologia moderada (por exemplo, afeto embotado e discurso circunstancial, ataques de pânico ocasionais) OU dificuldade moderada no funcionamento social, ocupacional ou escolar (por exemplo, poucos amigos, incapaz de manter um emprego)	60----------51
Sintomatologia grave (por exemplo, ideação suicida, rituais obsessivos graves, frequentes furtos em lojas) OU qualquer deficiência no funcionamento social, ocupacional ou escolar (por exemplo, ausência de amigos, incapaz de manter um emprego).	50----------41
Algumas deficiências em testes de realidade ou na comunicação (por exemplo, o discurso é, por vezes, ideológico, obscuro ou irrelevante) OU deficiência maior em várias áreas, tais como trabalho ou escola, relações familiares, juízos, pensamentos ou humor (por exemplo, homem deprimido que evita amigos, negligencia a família e é incapaz de trabalhar; é frequente a criança espancar outras mais novas, ter uma atitude de desafio em casa e mau rendimento escolar).	40----------31
O comportamento é consideravelmente influenciado por atividade delirante ou alucinações OU grave deficiência na comunicação ou nos juízos (por exemplo, por vezes incoerente, atua com rudeza despropositadamente, preocupação suicida) OU incapacidade de funcionamento em quase todas as áreas (por exemplo, fica na cama todo o dia; não tem trabalho, nem casa, nem amigos).	30----------21
Algum perigo de magoar-se a si próprio ou aos outros (por exemplo, tentativas de suicídio sem esperar claramente a morte; frequentemente violento; excitação maníaca) OU não consegue ocasionalmente manter a higiene mínima pessoal (por exemplo, suja-se com fezes) OU acentuada deficiência na comunicação (por exemplo, muito incoerente na expressão oral).	20----------11
Perigo persistente de magoar-se a si próprio ou aos outros (por exemplo, violência recorrente) OU incapacidade persistente para manter o mínimo de higiene pessoal OU suicida grave esperando claramente a morte.	10----------1
Informações insuficiente	0

Appendix G

Lubben Social Network Scale (LSNS6)

LSNS-6

No que diz respeito à sua família e amigos, assinale para cada questão a opção que mais se aplica à sua situação.

	0	1	2	3 ou 4	5 a 8	9 e mais
FAMÍLIA: *Considerando as pessoas de quem é familiar por nascimento, casamento, adoção, etc…*						
1. Quantos familiares vê ou fala pelo menos uma vez por mês?						
2. De quantos familiares se sente próximo de tal forma que possa ligar-lhes para pedir ajuda?						
3. Com quantos familiares se sente à vontade para falar sobre assuntos pessoais?						

AMIGOS: *Considerando todos os seus amigos, incluindo aqueles que vivem na sua vizinhança…*						
1. Quantos amigos vê ou fala pelo menos uma vez por mês?						
2. De quantos amigos se sente próximo de tal forma que possa ligar-lhes a pedir ajuda?						
3. Com quantos amigos se sente à vontade para falar sobre assuntos pessoais?						

Appendix H

Figure 1

CORE-OM Indexes comparison between Baseline and Final period of program

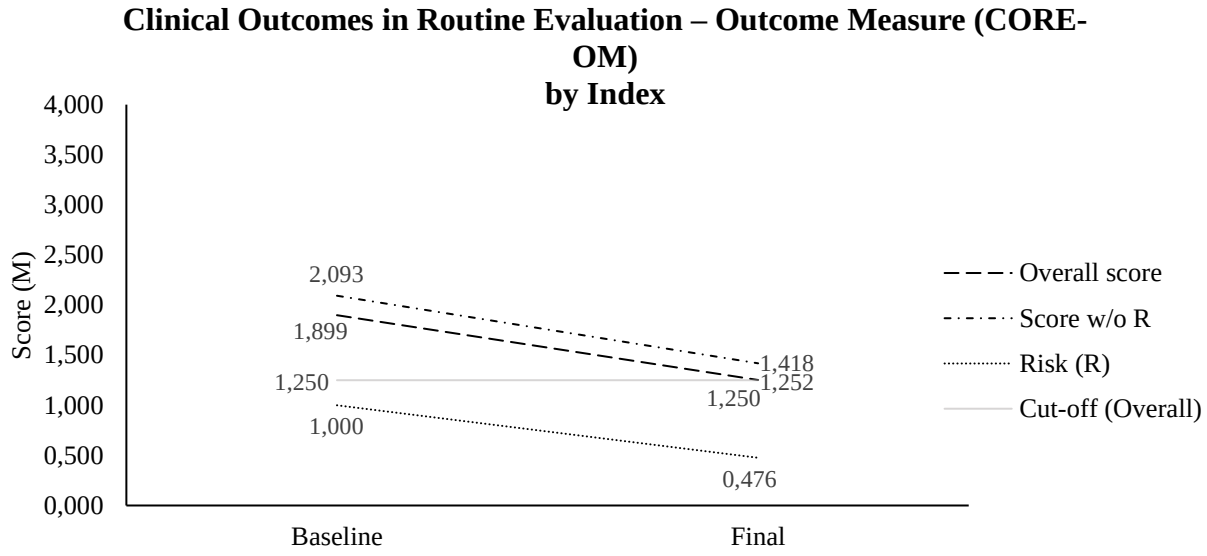
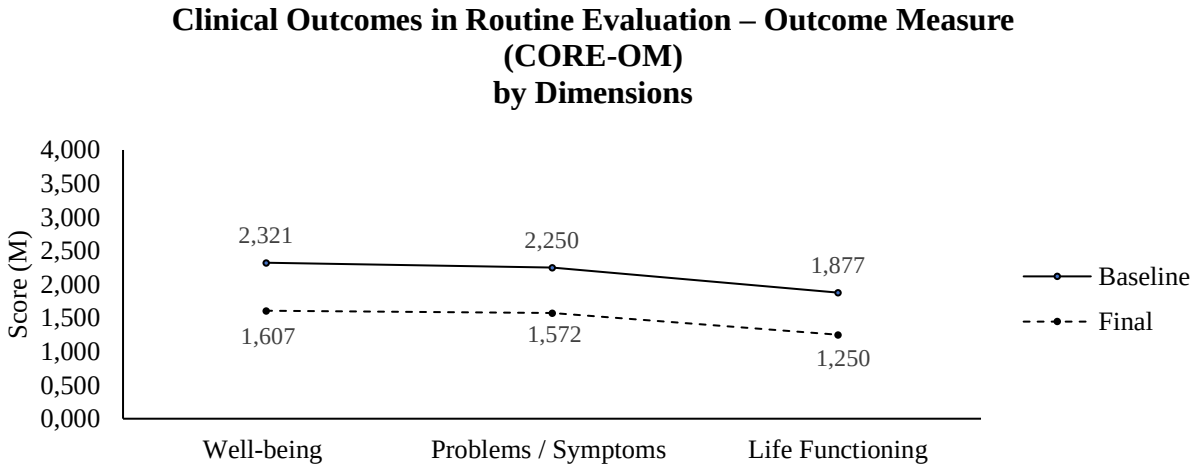


Figure 2

CORE-OM Dimensions comparison between Baseline and Final period of program



Appendix I

Figure 3

BSI Indexes comparison between Baseline and Final period of program

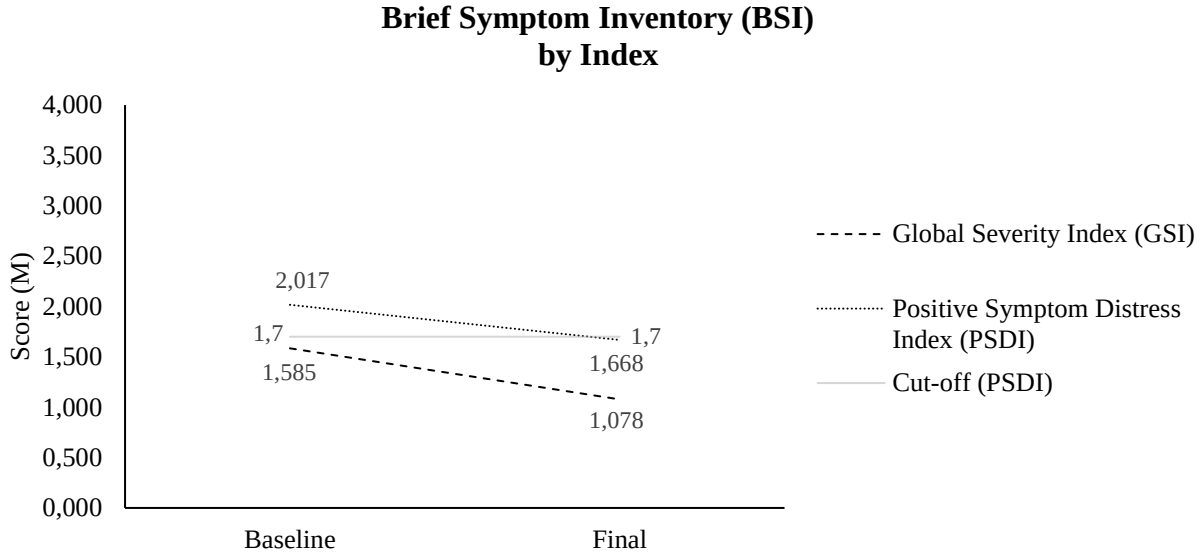


Figure 4

BSI Dimensions comparison between Baseline and Final period of program

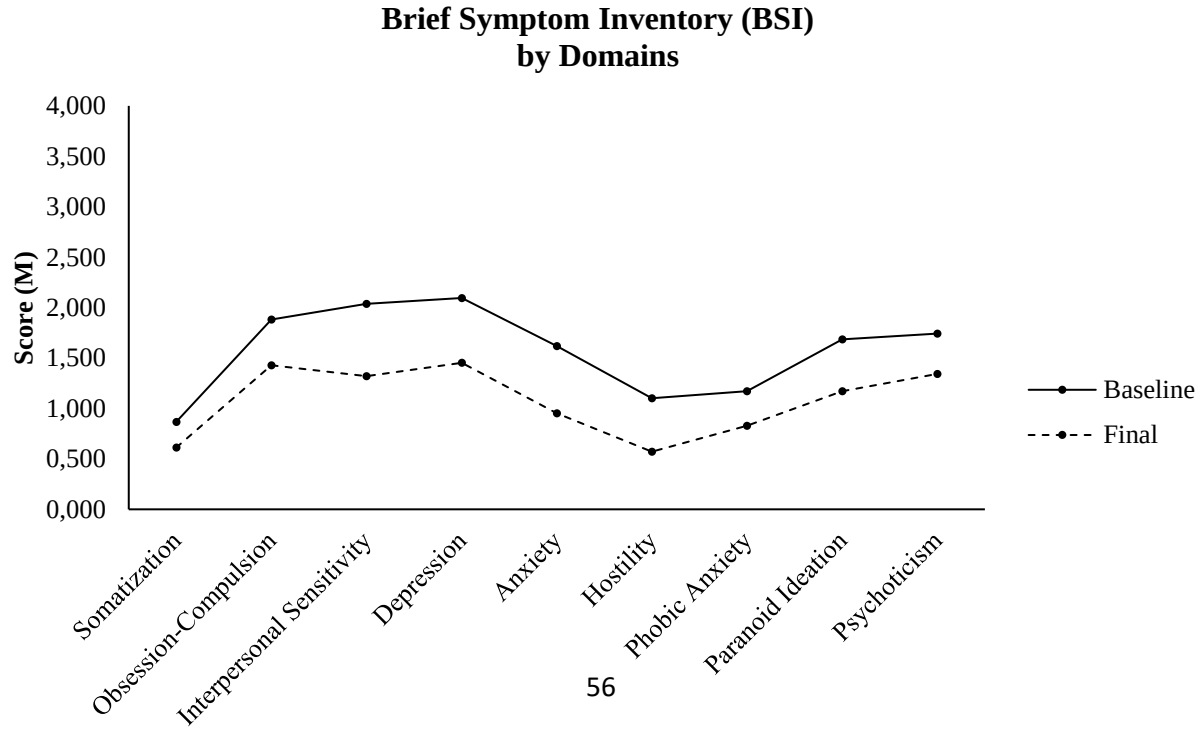


Table 3

Mean scores for BSI Dimensions and Indexes comparison between the OD program and the psychometric study of the Portuguese BSI

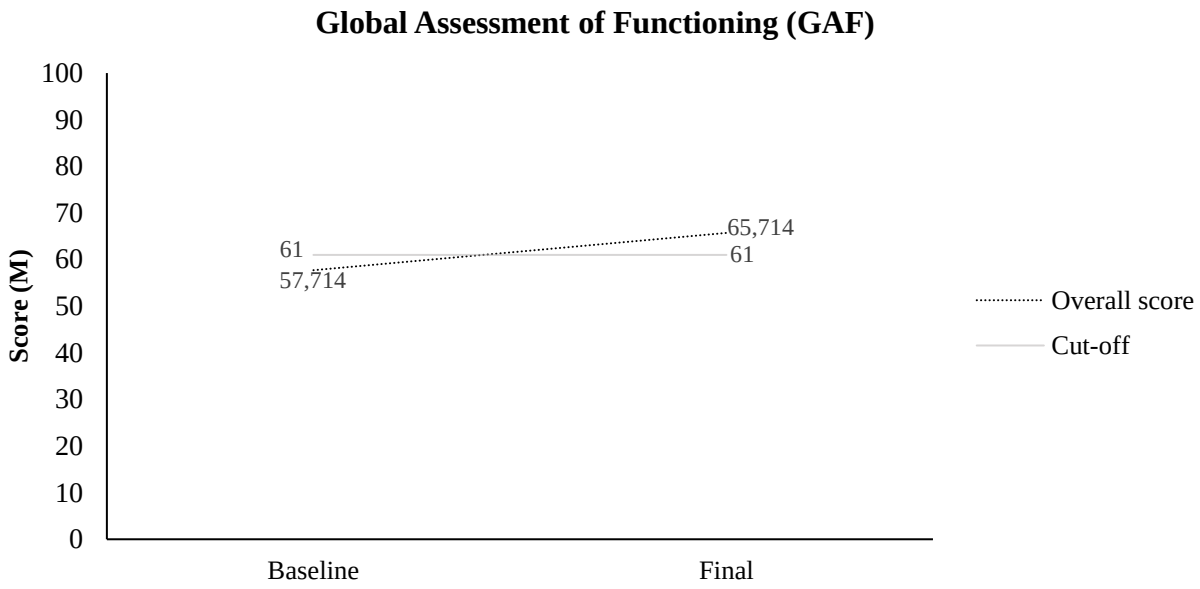
	OD program Baseline	OD program Final	Clinical Pop. (Canavarro, 1999)	Non-clinical pop. (Canavarro, 1999)
Symptom Dimensions	**M (SD)**	**M (SD)**	**M (SD)**	**M (SD)**
Somatization	.868 (.582)	.612 (.576)	1,355 (1.004)	.573 (.916)
Obsession-Compulsion	1,881 (.848)	1,428 (.615)	1,924 (.925)	1.290 (.878)
Interpersonal Sensitivity	2,036 (.929)	1,321 (.572)	1,597 (1,033)	.958 (.727)
Depression	2,095 (1,013)	1,452 (.731)	1,828 (1,051)	.893 (.722)
Anxiety	1,619 (1,035)	.952 (.416)	1,753 (.940)	.942 (.766)
Hostility	1,100 (1,066)	.571 (.214)	1,411 (.940)	.894 (.784)
Phobic Anxiety	1,171 (.812)	.829 (.697)	1,020 (.929)	.418 (.663)
Paranoid Ideation	1,686 (.773)	1,171 (.582)	1,532 (.850)	1.063 (.789)
Psychoticism	1,743 (1,130)	1,343 (.728)	1,403 (.825)	.668 (.614)
GSI	1,585 (0,744)	1,078 (0,351)	1.430 (.705)	.835 (.480)
PSDI	2,017 (0,628)	1,668 (0,224)	2.111 (.595)	1.561 (.385)
PST	40,000 (6,506)	33,517 (7,743)	37,349 (12,166)	26,993 (11,724)

Note. M – Mean; SD – Standard deviation; GSI – General Severity Index; PSDI – Positive Symptom Distress Index; PST – Positive Symptom Total.

Appendix J

Figure *5*

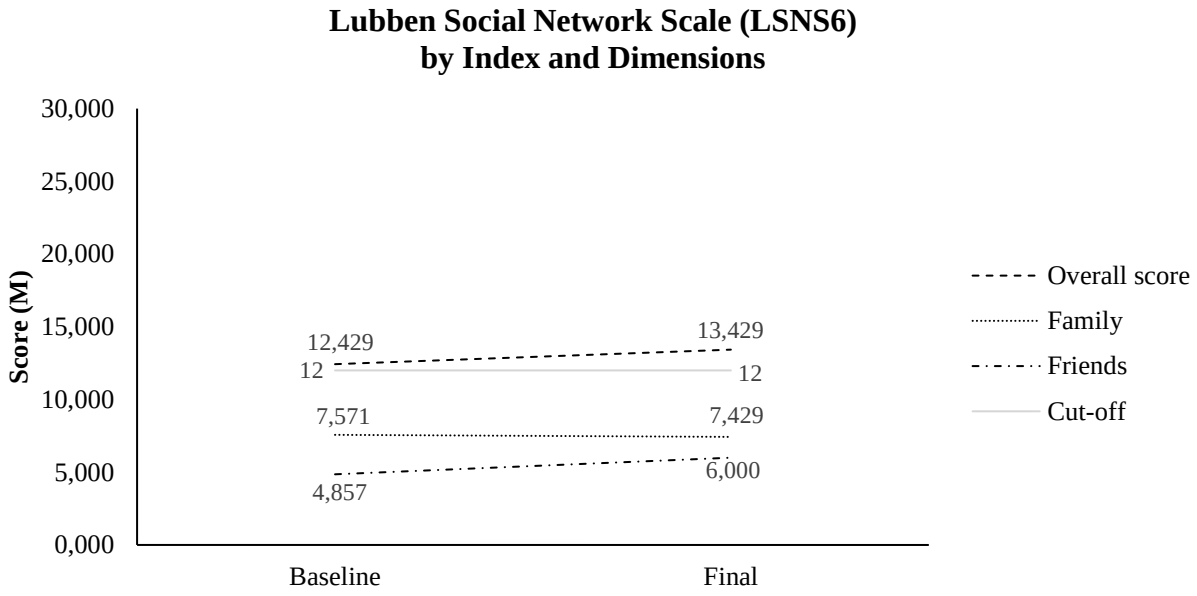
GAF overall score comparison between Baseline and Final period of program



Appendix K

Figure 6

LSNS6 Indexes and Dimensions comparison between Baseline and Final period of program



Appendix L

Table 6

Mean overall scores by marital status

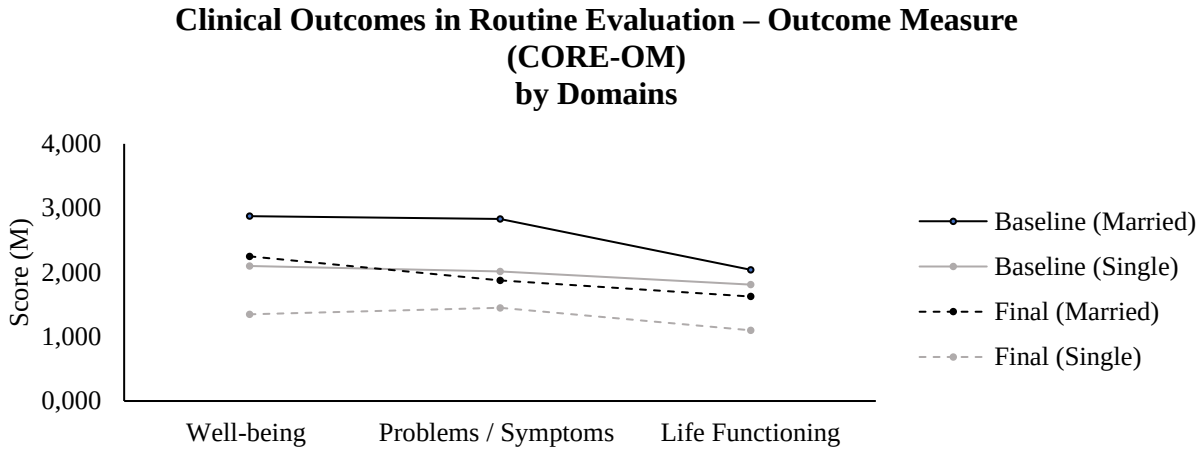
	M (baseline)	SD (baseline)	M (final)	SD (final)
CORE-OM (w/ R)				
Married	2,206	.499	1,574	.063
Single	1,776	1,021	1,124	.321
CORE-OM (w/o R)				
Married	2,482	.581	1,768	.025
Single	1,937	1,014	1,279	.375
BSI – GSI				
Married	1,868	1,068	1,406	.280
Single	1,472	.700	.947	.299
BSI – PSDI				
Married	2,235	1,021	1,854	.240
Single	1,930	.545	1,594	.192
BSI – PST				
Married	43,000	5,657	40,000	2,829
Single	38,800	7,014	31,000	7,681
GAF				
Married	56,00	7,071	59,00	19,800
Single	58,40	12,239	68,40	8,081
LSNS6				
Married	8,000	4,243	8,000	1,414
Single	14,200	5,263	15,600	2,608
LSNS6 (Family)				
Married	8,000	4,243	5,500	.707
Single	7,400	2,881	8,200	1,643
LSNS6 (Friends)				
Married	.000	.000	2,500	.707
Single	6.800	3,114	7,400	1,342

Note. GAF – Global Assessment of Functioning; BSI – Brief Symptom Inventory; GSI – General Severity Index; PSDI – Positive Symptom Distress Index; PST – Positive Symptom Total; CORE-OM – Clinical Outcome Routine Evaluation - Outcome Measure; R – Risk; LSNS6 – Lubben Social Network Scale; M – Mean; SD – Standard Deviation.

Appendix M

Figure 7

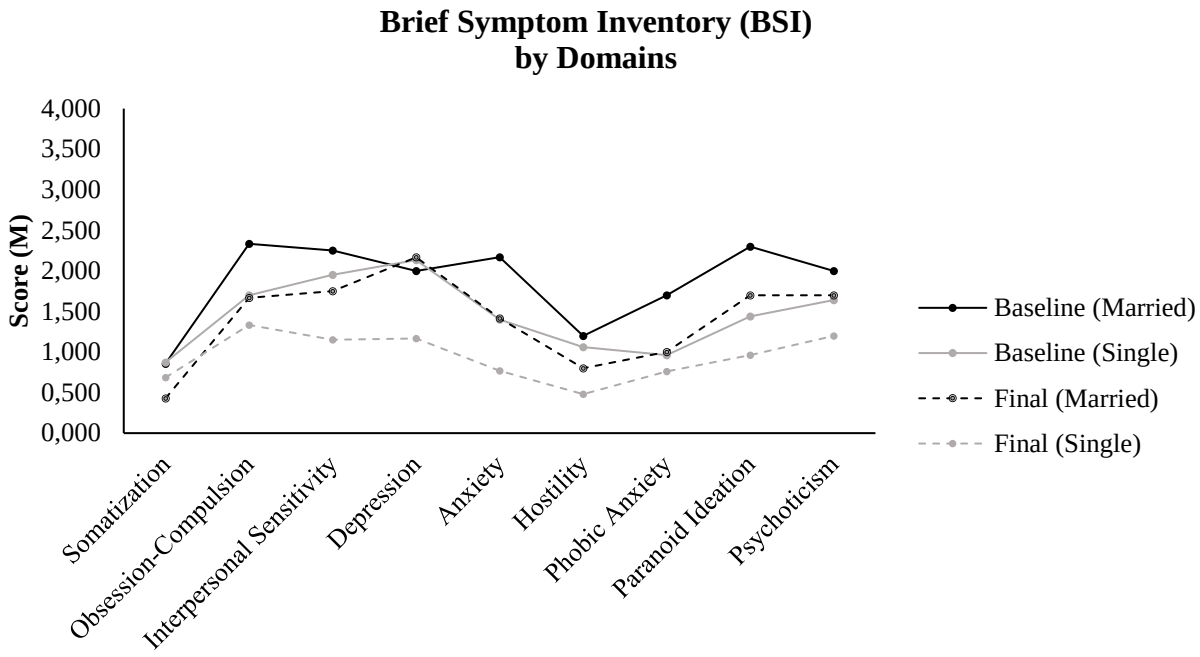
CORE-OM Dimensions by marital status



Appendix N

Figure 8

BSI Dimensions by marital status



Appendix O

Table 8

BSI correlations by dimensions

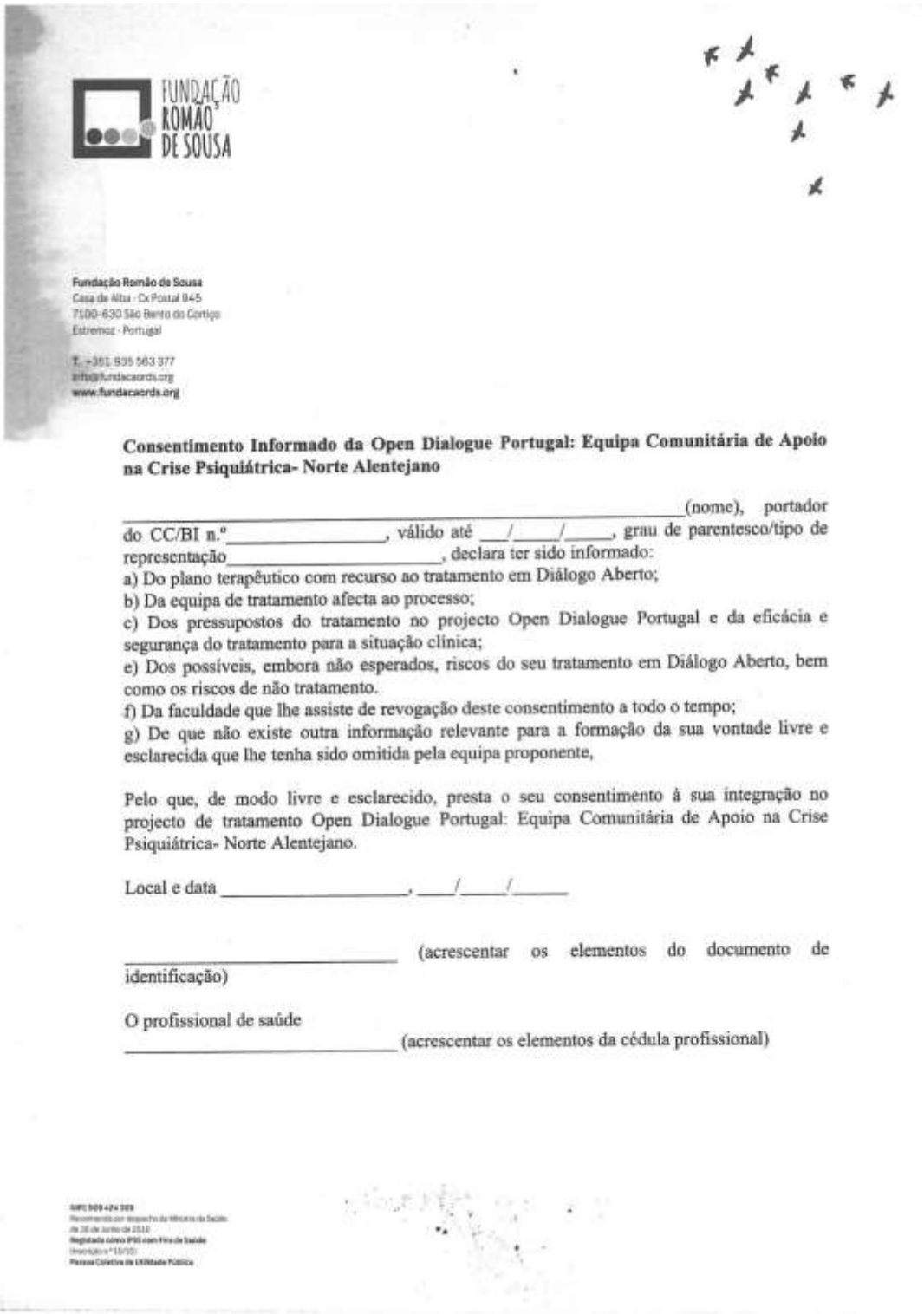
	1 Som	**2 Oc**	**3 Is**	**4 Dep**	**5 Anx**	**6 Hos**	**7 Pa**	**8 Pi**	**9 Psy**
1. Som		-.436	.275	-.028	.073	-.198	-.182	.327	.036
2. Oc	-.126		.670	.248	.245	.321	.700	.400	.745
3. Is	-.429	.793*		.472	.431	.486	.413	.743	.826*
4. Dep	-.018	.882**	.775*		.440	.934*	.101	.706	.193
5. Anx	.288	.827*	.559	.736		.359	.573	.418	.082
6. Hos	-.071	.847*	.857*	.847*	.631		-.009	.633	.330
7. Pa	.090	.755*	.414	.500	.882**	.468		.409	.391
8. Pi	.198	.436	.595	.473	.473	.541	.109		.645
9. Psy	-.180	.836*	.937**	.864*	.600	.955**	.373	.691	

Note. Below diagonal line: baseline mean scores; Above diagonal line: final mean scores; 1. Som – Somatization; 2. Oc – Obsession-Compulsion; 3. Is – Interpersonal sensitivity; 4. Dep – Depression; 5. Anx – Anxiety; 6. Hos – Hostility; 7. Pa – Phobic anxiety; 8. Pi – Paranoid ideation; 9. Psy – Psychoticism; *p.05; **p<.01.

All the statistically significant correlations found were positive and strongly/very strongly correlated.

Appendix P

Informed consent



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Consentimento Informado da Open Dialogue Portugal: Equipa Comunitária de Apoio na Crise Psiquiátrica- Norte Alentejano

_____(nome), portador do CC/BI n.º_____, válido até ___/_____/_____, grau de parentesco/tipo de representação_____, declara ter sido informado:

a) Do plano terapêutico com recurso ao tratamento em Diálogo Aberto;

b) Da equipa de tratamento afecta ao processo;

c) Dos pressupostos do tratamento no projecto Open Dialogue Portugal e da eficácia e segurança do tratamento para a situação clínica;

e) Dos possíveis, embora não esperados, riscos do seu tratamento em Diálogo Aberto, bem como os riscos de não tratamento.

f) Da faculdade que lhe assiste de revogação deste consentimento a todo o tempo;

g) De que não existe outra informação relevante para a formação da sua vontade livre e esclarecida que lhe tenha sido omitida pela equipa proponente,

Pelo que, de modo livre e esclarecido, presta o seu consentimento à sua integração no projecto de tratamento Open Dialogue Portugal: Equipa Comunitária de Apoio na Crise Psiquiátrica- Norte Alentejano.

Local e data _____, ___/_____/_____

_____ (acrescentar os elementos do documento de identificação)

O profissional de saúde

_____ (acrescentar os elementos da cédula profissional)