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Open Dialogue around the world – implementation, outcomes, experiences, and perspectives

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Open Dialogue around the world – implementation, outcomes, experiences, and perspectives

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Editorial: Open Dialogue around the world – implementation, outcomes, experiences, and perspectives

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Editorial on the Research Topic
Open Dialogue around the world – implementation, outcomes, experiences, and perspectives Introduction

Open Dialogue (OD) is receiving increased interest across mental health systems worldwide, inspiring practitioners, researchers, and policymakers to explore dialogical alternatives to conventional psychiatric models. Originally developed within the Finnish mental health system, OD is a systemic approach to care based on seven principles—five concerning the organization of services (immediate help, social network perspective, flexibility and mobility, psychological continuity, and responsibility), and two reflecting a dialogical way of being with service users and their networks (tolerance of uncertainty and dialogism). While previous studies have outlined the theoretical foundations and reported promising outcomes of OD, much remains to be understood about how the approach is translated into practice as it encounters varied professional cultures, institutional logics, and system-level constraints.

This Research Topic builds on the questions raised in our introductory paper (Mosse, Pocobello, et al.) and brings together 24 contributions from 105 authors, offering a multifaceted overview of current research and implementation efforts in OD. Through empirical studies, conceptual analyses, and methodological developments, the collection explores the opportunities and tensions that emerge as OD is applied in new settings and reinterpreted through diverse local experiences.

Implementing Open Dialogue in different contexts

The first section of the Research Topic examines how Open Dialogue has been implemented across different countries, reflecting a wide range of stages in its adoption and integration. Drawing on data from 24 countries, the HOPEnDialogue international survey conducted by Pocobello, Camilli, Ridente, et al. documents the growing global presence of OD, while also revealing considerable diversity in how its core elements are applied.

Some services report high fidelity to the original model developed in Western Lapland, while others follow OD-inspired practices that have yet to incorporate key principles such as immediate response, network involvement, and continuity of care. This variability illustrates both the adaptability of the approach and the challenges of sustaining its essential values across diverse settings.

Starting with the data collected through the HOPEnDialogue survey, Heumann et al. focused on analyzing the implementation of OD in Germany, a country where, despite hundreds of professionals being trained in OD since 2007 and more than 40 services practicing the approach in the year of the study, several obstacles were observed, such as the fragmentation of the system of care. Additional expert interviews suggest that the structure of the services, as well as specific features the German mental health care system, are likely to underlie these barriers. These findings highlight the importance of considering structural and systemic issues alongside training efforts to enhance successful OD implementation.

In Vermont, United States, Alpern et al. explored organizational challenges related to the implementation of OD-informed practice through anticipation dialogues—a dialogical practice that encourages participants to envision a positive future scenario. Beyond proposing anticipation dialogue as a research tool, the authors identified key dilemmas, including tensions between systemic uncertainty experienced by staff and the need for flexible, inclusive, and non-hierarchical approaches to support dialogic practice. The authors suggest that achieving a sustainable integration of Open Dialogue requires clear structural support and leadership commitment.

In Spain, where OD has been introduced in the last few years, Parrabera-Garcia et al. conducted a preliminary evaluation regarding training, experience, access to materials and events, and perceived needs in OD implementation. The survey revealed a lack of trained professionals as well as insufficient training hours and limited access to resources, underscoring an urgent need for enhanced local training initiatives and translated materials to support the delivery of OD.

In contrast with the Spanish bottom-up request, in South Korea OD has been introduced through a top-down initiative by the Ministry of Health and Welfare as part of a project to support the dissemination of WHO QualityRights-based services. A mixed-method survey by Cho et al., aimed at investigating the experiences of professionals, highlighted some perceived challenges and limitations, and provided practical recommendations on how to better align OD training and implementation guidelines with local cultural and systemic contexts.

Using a different methodology (i.e., a focus group), Skourteli et al. explored similar research questions in an action-research project conducted in Greece. Their study traces the implementation journey of OD in a Day Center for Psychosocial Rehabilitation in Athens, highlighting the challenges faced by mental health professionals and their contextualization within the local organizations and culture. This approach provides valuable insights into how local organizational cultures can influence the adoption of OD practices.

Klatt et al. further explore this theme by reflecting on the development of an initiative in Germany grounded in grassroots democratic values and a shared intention for change. Their account suggests that such organizational characteristics may support the integration of dialogical principles, particularly within a community of practice composed largely of young professionals. The authors also point to dissonance as a potentially productive element in addressing crisis and institutional transformation.

Within the same national context, von Peter et al. offer further insights based on data from an implementation study that struggled to retain practitioners engaged with OD. The authors argue that dynamics related to power and professional identity lie at the core of potential failures in OD adoption, raising thought-provoking questions to inform future implementation strategies.

Peer support, training, and professional reflections in Open Dialogue services

This section brings together studies that examine how Open Dialogue services are shaped by practices of peer support, professional training, and team reflection. These studies explore the development of participatory models, the articulation of core principles, and the challenges involved in communicating and embodying dialogical values within services.

Chmielowska et al. present a viewpoint on the importance of developing an OD model grounded in peer support and shared decision-making. Co-authored by individuals with lived experience of mental health issues, clinicians, and researchers, the paper offers a dialogical reflection on how values such as equality, transparency, and co-responsibility can shape team dynamics, supervision, and decision-making processes. It provides insights into the research and training needed to establish such a framework, while also acknowledging the tensions and uncertainties involved in co-producing a Peer-Supported Open Dialogue (POD) service.

On the same topic, Hendy et al. identified key principles that they described as foundational to Peer-Supported Open Dialogue. In their conceptual analysis, the authors suggest that defining these specific principles also has practical implications for the development of POD services, particularly in areas such as training, supervision, recruitment, and role specification. Their proposal of 10 evolving principles—including mutuality, attention to power, and dialogical responsibility—aims to support ongoing reflection and collective learning within teams, rather than setting fixed standards.

A qualitative study by Lorenz-Artz et al. explored how to better present and explain POD to professionals who have not received the POD training. Based on interviews with practitioners working in the Netherlands, the authors identified four key themes, including the use of metaphors, positioning of the professional, handling uncertainty, and the importance of embodying dialogical principles. Insights from interviews with POD professionals led to valuable recommendations, which can inform the development of further guidance for professionals unfamiliar with POD. Notably, the study emphasizes that communicating the essence of OD requires more than technical explanation—it demands engaging with its values and experiential qualities.

Reflections on training are also presented by Thorley et al., who contribute a dialogical conversation they describe as "part

(poly)-auto-ethnography and part perspective." Drawing on their personal experiences as trainers in four different countries, the authors also invite readers into the dialogue, encouraging them to pause and reflect on their own thoughts and reactions as they engage with their writing. Their text explores the uncertainties, challenges, and moments of growth encountered in delivering OD training, aiming not to offer definitive answers but to remain open to multiple voices and meanings—reflecting the very spirit of dialogical practice.

Experiencing Open Dialogue as a therapeutic process

Several papers in the Research Topic focus on the transformations associated with participating in network meetings, from the perspectives of the client, family members, and practitioners. These studies highlight how dialogical encounters can shape both therapeutic outcomes and professional identities, while also suggesting methodological tools to deepen understanding of these processes.

van Dieren and Clavero investigated the impact of reflective conversations on both the inner and outer dialogues of all participants. Beyond describing how reflections had an influence on the client and one of his family members, in their paper, the authors also propose the use of video-stimulated recall in social work, not only for research purposes but also as a tool that can further elicit new ideas and emotions. This method is presented as a dialogical tool in itself, offering practitioners a space to revisit conversations, recognize unspoken dynamics, and strengthen reflexivity.

Sidis et al. provided additional insights on the role of reflective conversations from the perspective of dialogical therapists. They present both the conceptualization of the reflective process and the concrete actions taken to facilitate it, offering insights into how OD professionals can cultivate and support this reflective attitude during network meetings. The authors explore how therapists maintain the balance between being present and facilitating reflection, pointing to the importance of emotional resonance, openness, and sustained attention to the evolving needs of the network.

Reflective processes were also explored by Lagogianni et al., who specifically focused on analyzing co-therapy dynamics during network meetings—a topic that, despite being central to the OD approach, has been scarcely investigated so far. By collecting information on the experiences of OD practitioners, the authors describe how co-therapy processes may develop and transform their own identity. The paper emphasizes that the therapeutic alliance extends beyond the client-therapist dyad, involving the relationship between co-therapists as a dynamic field of mutual adjustment, vulnerability, and growth.

On the same topic, Taylor et al. produced an auto-ethnographic account describing the changes they experienced as facilitators in network meetings over 2 years. Based on the positive impact felt by all three authors, they suggest that this transformation may lead to better outcomes in terms of staff retention, quality of life, and reduced burnout. Their narrative highlights how personal and professional boundaries are reshaped through dialogical work, and how training contexts themselves can become spaces of transformation and healing.

A different perspective is offered by Antoni, a physician who shares his 10-year experience applying OD in non-psychiatric settings. Reflecting on patients with physical symptoms potentially linked to psychological conditions, Antoni discusses the dilemmas other physicians may face when focusing on dialogue, their role as a "bridge between the biological and the psychic world," and how dialogism can be applied in different medical fields.

Outcomes of Open Dialogue interventions

While qualitative and process-oriented studies have provided valuable insights into the development and implementation of OD, promising results have also been achieved in the field of outcome studies.

Among these, a longitudinal study by Pocobello, Camilli, Alvarez-Monjaras, et al. represents one of the first efforts to systematically evaluate OD in routine public mental health care outside Finland. Conducted within Italian Mental Health Departments, the study followed 58 service users over one year and reported increased levels of satisfaction, improvements in psychological wellbeing and social functioning, a reduction in hospitalisations, and greater continuity in therapeutic relationships. These findings suggest that OD can be effectively integrated within community-based mental health systems committed to relational and recovery-oriented care.

In a brief research report, Tavares et al. describe a study conducted in the Alentejo region of Portugal that applied the same protocol to a smaller sample—seven service users and 21 network members. Despite the limited scale, the study contributes to the emerging international evidence on OD and underscores the importance of investigating outcomes across varied service contexts.

Methodological developments in Open Dialogue research

Various research methodologies and tools have been explored in the Research Topic, highlighting both the opportunities they offer and the challenges they raise in the evaluation of OD.

Mosse, Baker, et al. discuss the contribution of anthropology—particularly ethnography—to understanding POD practices drawing on their work conducted in parallel with the ODDESSI study (Pilling et al., 2021). The authors reflect on how this discipline can contribute to and complement other forms of evidence on OD, such as randomized controlled trial (RCT) outcomes, while also raising important questions regarding researcher roles, positionality, and ethical dilemmas that may arise in immersive fieldwork.

Lotmore et al. report on the development of an adherence scale for use in the ODDESSI trial to assess whether the OD intervention was being applied as intended. After demonstrating the psychometric properties of the scale through analyses of network meeting audio recordings, their work resulted in a manual outlining the rating process and defining key elements of OD.

As a complementary initiative, Alvarez-Monjaras et al. developed and implemented a measure to assess various structural and organizational aspects of high-quality mental health services. The Community Mental Health Team Fidelity Scale (COM-FIDE), which consists of 25 items plus a seven-item OD addendum, was piloted to evaluate staff interviews, yielding encouraging preliminary psychometric results.

Finally, Fedosejevs et al. developed the Peer-supported Open Dialogue Attitude and Competence Inventory (PODACI), a self-report tool designed to assess trainees' preparedness after completing POD training, as well as the effectiveness of the training course. The PODACI, comprising 27 domains and 76 items, was developed using a four-round modified Delphi procedure but has not yet been undergone formal validation.

Looking ahead

This Research Topic offers a broad and multifaceted overview of current research on Open Dialogue, while also pointing to important areas for further development. Advancing the theoretical understanding of how dialogical processes contribute to change remains a key priority—for clinical practice, for training and supervision, and for guiding future research.

As OD continues to diversify across settings and cultures, there is a growing need to revisit and elaborate its theoretical foundations, and to clarify what lies at the definitional core of this evolving field of practice. This also invites reflection on how our understanding of OD is shifting—whether as a clinical intervention, a paradigm for mental health care, or a broader movement for systemic and social change.

Greater involvement of service users and their social networks can play an important role in this process. Their perspectives offer insights that can deepen theoretical reflection and help ensure that evaluation remains connected to lived experience and everyday practice. Capturing outcomes and processes from their perspective is vital to understanding the ethical, relational, and transformative potential of OD.

Further consolidation of OD will require stronger empirical evidence, including results from randomized trials and large-scale international studies. Notably, there is currently a lack of studies on the use of medication within the context of Open Dialogue—an important aspect that should be addressed in future research. In parallel, more systematic implementation research is needed to understand how OD can be effectively and sustainably integrated into different service contexts. Hybrid studies that combine effectiveness and implementation outcomes may be particularly valuable, provided they adopt approaches consistent with the relational and dialogical principles of the model.

Another challenge lies in refining tools to assess fidelity and adherence to OD principles. Making these tools accessible and useful beyond research contexts—in training, supervision, and service development—could support ongoing quality improvement while maintaining coherence with the approach.

We hope this Research Topic will foster dialogue within the international OD community and encourage wider engagement with the OD approach. Continuing to build the evidence base remains essential to support its further development and broader adoption.

Author contributions

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Introduction: Open Dialogue around the world – implementation, outcomes, experiences and perspectives

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Introduction

There is an urgent need for innovative and alternative approaches in global mental healthcare systems given problems such as low rates of functional recovery, long-term dependence on psychoactive medication, pressure on hospital beds and crisis services, long wait-times, staff burnout and dissatisfaction from service users and their families. This Frontiers Research Topic focuses on Open Dialogue, a mental healthcare approach which has the potential to address some of these challenges and that is gaining worldwide momentum.

As this Research Topic will explore, Open Dialogue takes different forms across varied healthcare contexts but nonetheless has a core philosophy, values and set of principles. These were first developed and applied in Finland (Western Lapland) through a complementary process of therapeutic innovation and research over 40 years (Alakare and Seikkula, 2022). Open Dialogue brought change in local healthcare at two levels. First, a culture of dialogical communication between staff, service users and caregivers was established. Instead of an expert-led diagnosis-treatment model, service users and members of their social network were placed at the center of a dialogical process aimed at discovering ways out of crisis. Second, community-based, multi-disciplinary teams were organized to provide immediate help in crisis, accommodating service user and family needs, continuity of support by the same team and a primarily psychotherapeutically-oriented approach (minimizing medication use). These were the key emerging principles of Open Dialogue that have been further elaborated upon during the past decades (Olson et al., 2014).

Open Dialogue emphasizes the practitioners' capacity for empathy, presence and listening. It avoids interpreting others' experience through symptom-focused diagnoses. Instead, Open Dialogue encourages listening to what individuals and their families (or other kinds of social network) say about difficult experiences and events that have

happened to them. It attends to words and meanings spoken in the different voices of those who participate in Open Dialogue "network meetings" (Seikkula et al., 1995). These meetings are where important care decisions are made, openly and with those who are the focus of concern. Open Dialogue is thus based on a mental healthcare epistemology that prioritizes everyday relationships and context-bound understandings over clinical diagnosis; "being with" rather than "doing to". Transparency is important: all information is shared, and all voices are heard, thereby recognizing diversity and attempting to mitigate the effect of power differentials during the process of support.

This approach has implications for the organization of services to ensure immediate response to crisis, flexible and continuous care, and to enable work with multiple people in treatment systems which otherwise have an individualistic paradigm (Tse and Ng, 2014). Increasingly, Open Dialogue teams include people with lived experience as "peer" practitioners; but there is also a general expectation that the approach requires the skilled use of personal experience and emotions in dialogical encounters (Grey, 2019). This challenges conventional ideas on the source of clinical knowledge and definitions of expertise, changing established professional self-understandings and claims (von Peter et al., 2021). There are implications for clinical governance including responses to risk, clinical note-taking, discharge, flexible working and the boundaries around clinical work, as well as for training and supervision (Buus et al., 2021).

While presenting challenges to the conventional organization of mental healthcare, Open Dialogue has attracted attention from leaders and policymakers in different countries because of growing evidence from studies (initially from Western Lapland) for the effectiveness of the approach. Early research in Finland (Seikkula, 1991) "confirmed that immediate help, with the flexible involvement of the service user and their network, along with psychological continuity, were key factors in reducing the need for hospitalization" (Alakare and Seikkula, 2022, p. 47). The approach was subsequently found to be associated with reduced use of neuroleptic medication, maintenance of recovery from acute psychosis and return to education or employment (Seikkula et al., 2006, 2011; Aaltonen et al., 2011; Alakare and Seikkula, 2022). Research suggests not only that the experience of receiving (and delivering) care is improved, but also healthcare costs are reduced by Open Dialogue through faster recovery, reduced hospitalization, less time in treatment and reduced need for disability benefits (Bergström et al., 2018).

Alongside effectiveness, the ethical dimensions of Open Dialogue – justice, dignity, compassion – have promoted commitment to the approach. Open Dialogue is aligned to mental healthcare which is trauma-informed, and its person-centered and rights-based (von Peter et al., 2019) approach has recently been recognized as a "good practice" example of crisis services, promoting rights and recovery in the World Health Organization's "Guidance on community mental health services" (WHO, 2021). Open Dialogue also features in the Council of Europe's compendium of good practices intended to eliminate coercive practices in mental health settings as a matter of human rights (Council of Europe, 2021).

Why this research topic?

Open Dialogue is now practiced in various regions globally, in more than 24 countries, including several in Europe as well as Australia, Japan, India, Latin America and the United States (Pocobello, 2021). While originally a public sector service, Open Dialogue has now found applications in NGOs, associations and private practice. Services also vary regarding the groups they engage and the social context. Open Dialogue services have different inclusion and exclusion criteria. For instance, some exclude and others include people with learning difficulties (Fredman and Lynggaard, 2015); similarly in relation to people with drug or alcohol problems.

Relatively little is known about the practice and effectiveness of Open Dialogue in these different settings, and whether findings from the original studies in Finland are replicated. The question of how differences in the form and delivery of Open Dialogue might impact outcomes is crucial as Open Dialogue is adapted to local healthcare systems and contingencies. In view of the emerging diversity, it is an empirical question whether Open Dialogue is a clearly demarcated intervention or a broad approach manifest in a variety of local forms.

This Research Topic on "Open Dialogue Around the World – Implementation, Outcomes, Experiences and Perspectives" opens a window on the range and scope of research exploring different aspects and contexts of Open Dialogue. Through its inclusive set of contributions, the Research Topic aims to serve as a bridge between research and clinical practice. Indeed, the Open Dialogue approach is a system of care that has developed through its constant connection with ongoing research on the practice.

The Research Topic contributes to various kinds of inquiry that are currently the focus of Open Dialogue research and practice:

- At the broadest level, the results of an international survey of Open Dialogue services are presented, and the diverse variants of this approach and its organization within health care systems.
- Country or healthcare system-specific organizational studies provide case-studies, and comparisons of Open Dialogue services invited from across the globe. These present not only the adaptations to the initial incarnation of Open Dialogue, but also discuss the challenges to sustaining Open Dialogue practice in different healthcare systems. These organizational studies highlight the

healthcare bureaucracies to which Open Dialogue has to adapt, including systems of clinical governance, risk management, performance indicators and professional hierarchies. Open Dialogue can also bring institutional change through sometimes radically different notions of accountability. Here, Open Dialogue is understood in its political dimension: a reflection on institutional power and a movement for change, responding to the experience and demands of individuals, families and communities who may have had testing experiences of psychiatric systems.

- Further understanding is provided from studies on the internal organization and functioning of Open Dialogue services, including their particularity and distinctiveness. Accounts of training and supervision in Open Dialogue are valuable, both to describe service organization and also portray the subjective experience of trainers and trained. Accounts of Open Dialogue training continue to highlight its principles and their cultivation in terms of dialogical capacities such as listening, presence, embodiment, forms of questioning and reflection and the varied practices of presence, such as mindfulness that are incorporated into training. Investigation into the experience and organizational conditions of peer work in Open Dialogue – the opportunities and contradictions in different service structures – is also a growing area of inquiry (Razzaque and Stockmann, 2016; Grey, 2019) to which this Research Topic contributes.
- This Research Topic contains studies on Open Dialogue as a therapeutic process. Here research is accumulating fine-grained accounts of dialogical interactions and the meaning-making out of crisis. Since Open Dialogue is a social network approach, the relational dynamics of Open Dialogue's "network meetings" and their impact are of interest. The encouragement of different voices and viewpoints of participants (the "polyphony") and the way the truths of persons at the center and their family members come into dialogue with psychiatric knowledge, diagnosis and decision-making are productive fields of inquiry. The nature of Open Dialogue networks and family (or multi-family) involvement and the relational dynamics that unfold need to be understood. They are shaped by family systems and social-cultural environments in ways that are being discovered through Open Dialogue practice, and include particular challenges such as where relationships involve violence. As Open Dialogue diversifies into different settings, the affordances of cultural identity, kinship systems, different embodied, symbolic and linguistic repertoires come into play in collaborative meaning-making and fostering social connection that is involved in moving from crisis to recovery.
- Evidence on the outcomes of Open Dialogue is important for the status of Open Dialogue in global healthcare systems. The world's first large-scale multi-site cluster randomized controlled trial of Open Dialogue in the UK (ODDESSI) is under way and investigates the effectiveness of Open Dialogue within the UK's National Health Service (NHS) in comparison with established treatment models (Pilling et al., 2022). In parallel, randomized-controlled studies of Open Dialogue are being undertaken in other countries/health systems, across different statutory services and health insurance companies. Other non-randomized studies have focused on specific outcomes such as psychotropic medication prescribing across Open Dialogue/non-Open Dialogue client groups (in Finland) (Alakare and Seikkula, 2022). An international feasibility study named HOPEnDialogue is currently underway, and it aims to establish an evaluation framework to assess the outcomes of Open Dialogue internationally (Alvarez et al., 2021).
- This Research Topic pays attention to the fact that Open Dialogue services have been investigated through a range of research methodologies (Freeman et al., 2019; Buus et al., 2021), including multi-site observational studies used to test feasibility and efficacy (Harding et al., 1987; Seikkula et al., 2006). Open Dialogue experiences and outcomes have been studied through various survey instruments, including service-user (and family/social network member) self-report scales (e.g., quality of life, or perceived satisfaction with network sessions/service in general). Open Dialogue "key elements" criteria have been developed against which clinician adherence and organizational fidelity can be measured (Olson et al., 2014). Methods to evaluate Open Dialogue other than structured questionnaires measuring outcomes or adherence include descriptive case-studies of services or organizations and client case reports (or samples of these).

Assessing the process of Open Dialogue rather than outcomes *per se,* has brought in a range of qualitative methods such as focus group discussions (with clients and clinicians), recorded practitioner dialogues, team/peer group reflections, practitioner evaluative self-descriptions, subjective reflections and personal experience narratives (Rober, 2005; Gromer, 2012; Bøe et al., 2015; Cubellis, 2020; Dawson et al., 2021). Some Open Dialogue studies are framed as action-research to capture unfolding Open Dialogue programmes (Hopper et al., 2020), and long-term team-based ethnographic research by anthropologist-practitioners offers deep qualitative insight into Open Dialogue processes and effects (Pope et al., 2016; Cubellis, 2022; Mosse, in press). This research involves a phenomenological orientation to Open Dialogue, including attention to its emotional and embodied aspects, as well as the social, institutional and material context of Open Dialogue services (Cubellis et al., 2021).

- Alongside empirical studies, conceptual work has always been central to research and contributes to a still-nascent theory of Open Dialogue (Andersen, 1996; Seikkula, 2003; Seikkula et al., 2003; Shotter, 2011). Such analytical and philosophical reflections are not limited to viewing Open Dialogue in its own terms, but equally in relation to antecedent or adjacent therapeutic orientations whether systemic family therapy or psychoanalysis, both of which have influenced Open Dialogue.

Conclusion

Current Open Dialogue research and clinical practice, the breadth and depth of which is demonstrated in this Frontiers Research Topic, not only provide some answers to established to questions but also frame new ones. Much is yet to be discovered about Open Dialogue and the individual and institutional transformations it may entail. Questions on the salient core elements, the relevant variables, the institutional preconditions or barriers, the contextual factors of a given locality, client population or clinician group need to be constantly re-visited, while Open Dialogue as a field of therapeutic intervention spreads and diversifies across the globe. Gaining and sharing relevant knowledge requires active incorporation of research from different perspectives and subject positions including that of researchers and practitioners, clinicians and clients, peers, survivors and user researchers, and varied forms of collaborations alongside the multiplication of Open Dialogue across countries, sites and services.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Author contributions

DM wrote the first outline draft of the article, based on contributions from other authors. All authors contributed to the development, finalization, and approval of the article.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Open Dialogue services around the world: a scoping survey exploring organizational characteristics in the implementation of the Open Dialogue approach in mental health services

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Objective: This cross-sectional study investigates the characteristics and practices of mental health care services implementing Open Dialogue (OD) globally.

Methods: A structured questionnaire including a self-assessment scale to measure teams' adherence to Open Dialogue principles was developed. Data were collected from OD teams in various countries. Confirmatory Composite Analysis was employed to assess the validity and reliability of the OD self-assessment measurement. Partial Least Square multiple regression analysis was used to explore characteristics and practices which represent facilitating and hindering factors in OD implementation.

Results: The survey revealed steady growth in the number of OD services worldwide, with 142 teams across 24 countries by 2022, primarily located in Europe. Referrals predominantly came from general practitioners, hospitals, and self-referrals. A wide range of diagnostic profiles was treated with OD, with psychotic disorders being the most common. OD teams comprised professionals from diverse backgrounds with varying levels of OD training. Factors positively associated with OD self-assessment included a high percentage of staff with OD training, periodic supervisions, research capacity, multi-professional teams, self-referrals, outpatient services, younger client groups, and the involvement of experts by experience in periodic supervision.

Conclusion: The findings provide valuable insights into the characteristics and practices of OD teams globally, highlighting the need for increased training opportunities, supervision, and research engagement. Future research should follow the development of OD implementation over time, complement self-assessment with rigorous observations and external evaluations, focus on involving different stakeholders in the OD-self-assessment and investigate the long-term outcomes of OD in different contexts.

KEYWORDS

Open Dialogue, mental health services, self-assessment, peer support, scoping survey, implementation, mental health training, global survey

1. Introduction

Finding its roots in Need-Adapted Treatment (Alanen et al., 1991; Alanen, 1997), OD emerged as an innovative approach within the Finnish Western Lapland mental health services during the 1980s and 1990s. Seven principles became evident during the first research programs and psychotherapy training: (1) immediate help, (2) a social network perspective, (3) flexibility and mobility, (4) responsibility, (5) psychological continuity, (6) tolerance of uncertainty, and (7) dialogism (Seikkula et al., 2001). The first five principles regard the organizational logistics in which mental health services are provided, while the last two refer to the dialogic practice in which mental health professionals engage during network meetings with clients (Seikkula et al., 2003).

Since the 1990s, positive outcomes associated with OD have been documented in Western Lapland (Seikkula et al., 2006). Researchers observed that 82% of patients experiencing acute psychosis following the OD treatment showed no symptoms at the 5-years follow-up. Moreover, 86% of the patients had returned to a full-time job or studies, whereas only 14% were on disability allowance. Encouraging results were also observed during the following decade. A follow-up study confirmed that more than 80% of patients treated with the OD approach were fully employed or engaged in their studies after 2 years (Seikkula et al., 2011). Moreover, the study highlighted a cultural change in the use of the mental health service that led to earlier initiation of treatment, with a shorter duration of untreated psychosis and patients' first contact happening at a lower age. Findings from a nineteen–year outcomes study indicated that many positive outcomes documented in previous studies are sustained over a long period (Bergström et al., 2018, 2022).

By 2011, OD was "well-established" in Western Lapland but still "little-known elsewhere" (Thomas, 2011). However, in the following decade, the approach started to be applied globally in different contexts and with disparate results. A review which focused on OD implementation in Scandinavia outside of Finland highlighted a significant variety of OD applications that, according to the authors, could be related to the intentional lack of operationalization of the OD principles (Buus et al., 2017). Other authors suggested that the different integrations of the OD approach into clinical practice may depend on the double challenge of introducing a transformation at the individual and the service level (Freeman et al., 2019).

Notwithstanding the heterogeneous panorama of OD applications, the approach has been investigated mainly using a naturalistic research design. The first randomized controlled trial on OD, evaluating the approach's clinical and cost-effectiveness, was launched in the UK in 2017. The trial is part of the ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) research program and compares OD against standard treatment in six mental health services in the UK. Results are expected in 2024 (Pilling et al., 2022).

Overall, the gradual implementation of OD into mental health services has not been described in detail, not even in Finland, despite the breadth of studies reporting on the origin of the approach (Buus et al., 2021). Research focusing on the implementation obstacles has been very scarce for many years, with one study describing organizational challenges observed among the nursing staff in Finland (Haarakangas et al., 2007) and a case study reporting the difficulties of an outreach team practising OD in Denmark (Søndergaard, 2009). More recent research (Gordon et al., 2016; Heumann et al., 2023; Skourteli et al., 2023) highlighted organizational and ideological barriers such as lack of time and resources, rigid professional hierarchy and the burden of working across two different models at the same time (Dawson et al., 2021; von Peter et al., 2023). Although these qualitative studies suggest some adaptation strategies, more global and quantitative research on the implementation of the OD approach is still needed.

Moreover, the fact that the OD approach has not gone through the process of manualisation – that is, the development of a procedure that can be replicated with sufficient uniformity (Waters et al., 2021) poses additional challenges, especially in assessing OD-fidelity. A measure called COMFIDE (Alvarez Monjaras, 2019; Alvarez-Monjaras et al., 2023) was developed as part of the ODDESSI trial to evaluate a good standard of care for community mental health services providing OD and standard crisis and community care. Although more research on OD-fidelity is needed to identify specific and measurable elements (Waters et al., 2021), items and topics from the COMFIDE scale may currently be used for fidelity assessments at a global level.

Different approaches to implement Peer supported Open Dialogue (POD), connecting social and professional networks, have also been described in the last years (Razzaque and Stockmann, 2016; Kemp et al., 2020; Lorenz-Artz et al., 2023). Bellingham et al. (2018) reported that several models of POD had been embedded into clinical practice. In some cases, peer supporters may have a role very similar to that of professional therapists, whereas, in others, they have more limited space. For example, persons with lived experience may not participate in network meetings but be involved as supporters of the community. In other models, they may participate in the network meetings but not attend the reflection spaces addressed only to the clinicians (Bellingham et al., 2018). Due to the heterogeneity of models and scarcity of research on peer workers, a more comprehensive investigation is needed in this area (Kemp et al., 2020).

Pivotal elements in the development of OD services are training, supervision and intervision which need to be "carefully planned" and considered an integral part of the approach (Buus et al., 2017) – intervision is hereby a form of colleague-based supervision practised in Peer-Supported Open Dialogue (see Razzaque, 2019). In Western Lapland, the training of the staff members was one of the three central components of the

community psychiatric system (Alakare and Seikkula, 2021), together with the "Family and Team-centeredness" and the research project (Seikkula et al., 2011). Training activities cover theory, supervision, and seminars in which participants are required to analyze their background and family of origin. Experiences of training from different countries, including Norway, the US, the UK, Australia and Italy, have been reported in the literature (Hopfenbeck, 2015; Aderhold and Borst, 2016; Buus et al., 2017; Cubellis, 2020; Florence et al., 2020; Hopper et al., 2020; Jacobsen et al., 2021; Schubert et al., 2021; Pocobello, 2021b). Intervision, intended as a form of colleague-based supervision, and training, including "intentional peer support," are also part of the activities for peer workers (Hopfenbeck, 2015; Razzaque and Stockmann, 2016; Razzaque, 2019; Hopper et al., 2020). As far as we know, there has been no global investigation on the extent of training and supervision practices in OD services worldwide. Quantitative data on how many people involved in OD services have completed or are completing the training are unavailable. Moreover, the frequency and type of supervision have not been explored so far.

Overall, the requirements for and barriers to the implementation of OD on both the level of organizational structures and staff competencies need to be addressed in research and require a deeper investigation (Mosse et al., 2023).

The present scoping survey was designed to map and explore the existing evidence about the implementation of OD-services globally (Pocobello, 2021a) and to investigate the impact of factors such as OD-training, supervision, research, the involvement of experts by experience and organizational characteristics on services' OD-self-assessment (OD-SA). In this context, the term "expert by experience" refers to an individual who has/had personal, lived experience with mental health challenges or the mental health care system. This term acknowledges that individuals who have gone through these experiences possess a unique and valuable perspective that can contribute significantly to the improvement of mental health services, policies, and practices (Gupta et al., 2023).

The objectives of the global scoping survey can be summarized as follows:

a. To describe services practising Open Dialogue around the globe;
b. To pilot testing and validating an Open Dialogue Service Survey Scale including an OD- self-assessment (OD-SA) scale;
c. To construct an exploratory model of the organizational predictors of OD self-assessment;
d. To provide a measure of teams' degree of self-assessed adherence to the seven OD principles and
e. To identify services ready for outcome evaluation studies.

The study is part of the project HOPEnDialogue,[1] financed by the Open Excellence Foundation, which aims at investigating the implementation and effectiveness of Open Dialogue in different mental health care contexts around the world.

1 https://www.hopendialogue.net/

2. Methods

The study is reported according to the CROSS Checklist for Reporting Survey Studies (Sharma et al., 2021) to ensure rigor and credibility.

2.1. Study design

We used a cross-sectional study design to collect data from multiple teams providing OD services in mental health care across different countries. The study design involved (1) the development and validation of a OD-self-assessment scale and (2) a quantitatively structured questionnaires to gather information on various aspects of OD services, including their structural characteristics, personnel OD-trainings, as well as practices regarding supervisions, involvement of experts by experience, and research activities.

2.2. Ethical clearance

All respondents to the survey have completed an informed consent form embedded in the first page of the questionnaire. A skip-logic survey method was in place in the online form to ensure no collecting of information from respondents who disagreed with the informed consent question. Respondents were informed about the possibility of withdrawing from the survey at any time. Respondents could leave questions not answered.

The survey was not anonymous, since the address of the service and personal contact information of the professional completing the survey on behalf of the OD team was used to check for accuracy and prevent multiple participation. Confidentiality was guaranteed by limiting access to this information to the research team of the ISTC-CNR and saving electronic data on password-protected computers.

Ethical clearance with authorization value was not necessary for this study.

2.3. Respondents

Team members of OD-services with leadership responsibility were invited to complete the survey on behalf of the entire facility or OD-team. Individual OD practitioners were excluded.

As the survey is part of the project HOPEnDialogue, it was advertised and primarily distributed through its website Members of the HOPEnDialogue advisory board helped disseminate the survey in their different countries and networks through social media and mailing lists. We have contacted professionals from countries not represented on the board to ask for their support in spreading the survey at a national or local level. The first round of data was collected online using the Survey Monkey platform from January to September 2020. In total, 136 questionnaires were filled out online. The data were exported into Excel. The second round of data collection happened from January 2021 to February 2022 and involved six teams just concluding their foundation training. The questionnaires were filled and sent as PDFs to RP and FC, who added them to the Excel data set. The reason for this late recruitment was related to our intention to

include all the services contacting us to have as much as possible comprehensive view of OD implementation globally. In total, 142 services participated in the survey.

2.4. Data diagnostics

Data was checked and controlled for consistency. Where available and possible, missing data were completed by checking back with survey responders via email. Of the 142 questionnaires received during the data collection period, the data of 24 OD-services had to be excluded due to incomplete datasets, mainly from the 6th item (clients' characteristics served in the center) onwards. Often, the unavailability of informants made it impossible to assist in completing the missing questionnaire sections. We undertook a missing data diagnosis on the data from the remaining 118 centers and did not detect systematic patterns (checking summary statistics for variables, counting the number of missing and non-missing values for each variable, correlations to examine if the missingness in one variable is associated with another variable).

2.5. Data analysis strategy

To evaluate the statistical validity and reliability of the measurement model of the OD-self-assessment (OD-SA) scale, non-parametric Confirmatory Composite Analysis (CCA; Dijkstra and Henseler, 2011; Schuberth et al., 2018) was calculated with SmartPLS 4® (Ringle et al., 2022). We followed the procedural steps for CCA outlined by Hair et al. (2020). The reliability of the variables was tested using Cronbach's Alpha and Composite Reliability (ρ_A).

Descriptive data of the survey have been checked for consistency in Excel spreadsheets and transferred to SPSS® 27.0 (IBM Corp, 2020) for the descriptive and explorative Cluster analysis.

For the descriptive analysis Continuous variables were described using means (M) and standard deviation (SD); for discrete count variables, proportions were reported. The Shapiro–Wilk test was used to assess the normal distribution of continuous variables. As a non-parametric test for differences in group value of *p*s Kruskal-Wallis' test was used. Association between structural aspects of OD-services was assessed using Loglinear modeling when it concerned the frequency of categorical data (see structural characteristics). The significance level was determined as $p < 0.05$ for all analyses.

For the explorative data analysis bivariate non-parametric correlations were computed between the services OD-SA score and the descriptor variables to identify significant associations.

- To explore structural characteristics of the MHS in which OD-teams emerged and operated, an unsaturated model was chosen using SPSS Statistics' hierarchical loglinear model selection process with a backwards elimination stepwise procedure;
- To explore professional taxonomies in OD-services hierarchical cluster analysis was used; Provided the sample size of $n = 118$ teams, the number of clusters was estimated to range between $n/30 = 4$ and $n/60 = 2$. To identify equally sized clusters, hierarchical cluster analysis with Ward's method was used. Count values per variable of the eight professional profiles was standardized to correct for important differences in the counts of personnel in teams. A chi-squared measure of distance was used as a similarity measure;
- A Kruskal-Wallis' test was calculated to test for significant differences between the OD-teams belonging to different professional clusters. Visual inspection of boxplots was used to assess the similarity of the distributions of OD-SA scores (OD-SA 15) of groups/clusters. Pairwise comparisons were performed using Dunn's (1961) procedure with a Bonferroni correction for multiple comparisons. Adjusted value of *p*s are presented.

Finally, partial least squares (PLS) regression analysis was conducted to explain the variance of OD-Teams self-assessment scores based on teams- and their services' characteristics. PLS regression, is a statistical method used in the presence of many predictor variables which may be highly correlated. It is especially useful when the number of predictor variables is larger than the number of observations, a situation where traditional regression methods like ordinary least squares (OLS) struggle (Hair et al., 2018).

The Breusch-Pagan test was used to assess Heteroskedasticity; the PLS algorithm was set to heteroskedasticity consistent standard errors (HC3) to handle the distribution in case of a positive Breusch-Pagan test. HC3 correction calculates robust standard errors that take into consideration the potential heteroskedasticity in the data. It provides more accurate standard errors that are less affected by the presence of heteroskedasticity. This, in turn, ensures that hypothesis tests and confidence intervals derived from the regression analysis are more reliable and valid, even when heteroskedasticity is present (Kaufman, 2013). To deal with missing data the algorithm was set to mean replacement (no weighting vector was used).

2.6. Instruments: the Open Dialogue teams survey scale development

RP and TeS developed a first draft of the questionnaire after reviewing the current literature on OD implementation. All authors revised the first draft, and RP further refined the revisions until a consensus was reached. At the end of the development process, 65 questions were finalized for this survey. The full questionnaire is attached as Supplementary material to the article. The items related to OD-team's transparency, self-disclosure, intervision, intended as a form of colleague-based supervision (Razzaque, 2019) and training were adapted from the OD addendum of the COMFIDE-Questionnaire (Alvarez Monjaras, 2019). The questionnaire was then pilot tested with one OD team, but no changes to the survey content were necessary.

The survey was structured in six sections, each dedicated to an independent dimension of mental health services. In the general part (1) the year the OD-service first started, (2) the presence of other therapeutic models integrated in the mental health service; (3) the age range of patients the OD-service was dedicated to; (4) what diagnostic groups of patients the OD-service works were inquired. Furthermore, three characteristics of the structural domain of mental health services were inquired: (a) the sector to which the MHS belongs [public/other (private, third sector); since the distinction between the private and third sectors was not always clear to respondents, we collapsed these two categories into one category ('non-public sector')]; (b) whether the MHS operates as an inpatient or outpatient service, or both; (c) if

the MHS is stand-alone- or integrated with other services or other. We further asked about estimating the number of professionals (nurses/occupational therapists/peer-support workers/psychiatrists/psychologists/psychotherapists/social workers /support workers/others) constituting the OD-team.

2.6.1. OD-self-assessment scale: development and validation

For the teams' OD-self-assessment (OD-SA), we developed 17 items by reviewing the literature on good practice in Open Dialogue. The starting point for the development of the items were the seven principles of OD (Seikkula et al., 2003) with the aim of formulating a minimum of two items for each principle as affirmative statements. Respondents were asked to indicate for each statement the extent to which it reflected the clinical practice in their services over the past 3 months on a five-point Likert scale from 1 = "never," 2 = "rarely," 3 = "sometimes," 4 = "frequently" to 5 = "almost always." Consequently, higher scores reflected better OD-self-assessment (OD-SA) than lower scores.

2.6.2. Scale validation: confirmatory composite analysis

The content validity of the 17 items composing the OD-self-assessment scale is based on the conceptual review of the OD-Principles formulated by Seikkula et al. (2003).

Discriminant validity refers to the extent to which model constructs may be distinguished from each other. Different to the first five organizational principles, principles 6 (Tolerating Uncertainty) and 7 (Dialogicallity) relate to the way of being and engaging with clients during the network meetings. Due to a low discriminant validity of the two scales – Heterotrait-Monotrait ratio (HTMT) of 0.917 was above the recommended 0.900 threshold (Henseler et al., 2015) – they were merged into one four-item scale of 'OD-Adherence' (OD-ADH). For the resulting scales the values of average variance extracted (AVE) exceeded the Fornell and Larcker (1981) criterion (a minimum of 0.5) and HTMT ratio was significantly below 0.90 indicating a good discriminant validity.

Assessing first Cronbach's alpha reliability of the constructs, it turned out to be 'good' for P1 (r = 806) and P2 (r = 0.806), acceptable for 'ADH' (r = 0.767) however 'doubtful' for P3 (r = 0.683), P5 (r = 0.632), and 'not acceptable' for P4 (r = 0.332). Reviewing all factor loadings, we eliminated two critically low loading items (I26: λ = 0.52 -> P3; I30: λ = 0.63 -> P4) from each of the two scales, turning the P4 scale into a single-item construct consisting of I29 only and the P3 scale into a three-item scale with close to 'acceptable' reliability (r = 0.698); the internal consistency of P5 (r = 0.623) remained low according to the generally applied Cronbach's Alpha criterion (r = 0.705).

New research suggests that the use of a single criterion for established instruments as well as newly explored and developed studies – as the one at hand – may be too conservative for scales developed within the context of the latter (see Hair et al., 2019, p. 9; Hair et al., 2021, p. 119). Composite reliability is therefore recommended for the reliability assessment of newly developed scales (Hair et al., 2018) and the values evidence the scales acceptable level of reliability according to the standards for exploratory studies (see ρ_A in Table 1).

Multicollinearity appeared not to be an issue for our indicators since each indicator's Variance Inflation Factor (VIF) value was less than 5. Convergent validity and reliability results are presented in Table 1.

Confirmatory Composite Analysis provided evidence of the measurement model's construct validity based on the assessment of its convergent and discriminant validity. Nomological validity is confirmed through the positive correlations of the six subscales. The full OD-FID15 scale had a high level of internal consistency, as determined by Cronbach's alpha of r = 0.823. The computed Cramér-von Mises test statistic (CVM = 0.16, df = 118, p = 0.017) for the composite scores indicated a significant deviation from the normal distribution (skewness = −0.238, kurtosis = −0.203).

3. Results

During the timespan January 2020 – February 2022, a total of 142 OD-Teams from 24 different countries responded to the call to participate in the survey. 118 OD-teams (82%) completed the questionnaire responding to the entire OD-self-assessment (OD-SA) scale. We report the number of respondents for each item related to the quantitative data.

3.1. Descriptive data

The first OD-mental health services participating in our survey were established in Finland during the 1990ies. This Finnish service remained for about half a decade the pioneering mental health center for the treatment of severe mental illness using OD; in 1995, another center started to offer the OD approach in Norway.

The year 2006 marked a significant turning point in the spread of the OD approach, from where on we observed a stable growth rate of new OD-services of about 24% (SD = 17%) on a yearly basis from five OD-services in Finland and Norway in 2006 to over 100 centers in the year 2020 in 24 countries on five continents (see Supplementary Figure 1).

Geographically, 85% of OD services were based in Europe, with a presence in almost all North-European countries (except Sweden and Island) and Western Europe (except Austria and Luxemburg; see Figure 1).

3.1.1. Structural characteristics of OD-services

Of the 118 OD-services who completed the survey, 57 (48%) were mental health departments, 42 (36%) were registered associations, 9 (8%) were private practices, and 4 (3%) were foundations; 6 (5%) did not report their legal form of entity. Most teams (62%) belonged to MHS of the public sector, and 45 (38%) OD-teams belonged either to the private sector (n = 25) or to the third sector (n = 20). None of the teams reported to belong to MHS offering only inpatient service but 42 (36%) offer in-& outpatient service; 76 (64%) offer only outpatient service (see Table 2).

Exploring the structural characteristics associated with the MHS in which OD-teams emerged and operated, resulted in a model including all main effects and two two-way associations: (1) Service Sector * Integration; (2) Service Sector * Service Modality. The likelihood ratio goodness-of-fit test indicated that the model offered a moderate fit to the observed data [$\chi^2(2) = 4.929$, p = 0.085]; the

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TABLE 1 Measurement model of the 15 items of the OD-self-assessment (OD-SA) scale: descriptive statistics, factor loadings (λ), Cronbach's alpha, composite reliabilities (ρ_A, and ρ_c), average variance extracted (AVE).

Reliability measures								P1	P2	P3	P4	P5	P6-7: ADH
M (*SD*)								**2.96 (1.01)**	**3.80 (0.91)**	**4.51 (0.55)**	**3.83 (1.16)**	**4.29 (0.83)**	**4.10 (0.73)**
Cronbach's alpha								0.806	0.806	0.698		0.632	0.767
Composite reliability (ρ_A)								0.826	0.808	0.695		0.710	0.774
Composite reliability (ρ_C)								0.911	0.886	0.832		0.839	0.851
Average variance extracted (*AVE*)								0.836	0.721	0.622		0.724	0.588
Principle	**Item**	***M***	***SD***	**Λ**	***t*-statistic**	***p* value**	***VIF***	**P1**	**P2**	**P3**	**P4**	**P5**	**P6-7: ADH**
P1	I18	2.47	0.99	0.897	32.489	0	1.835	0.897	0.493	0.371	0.352	0.120	0.369
P1	I19	3.46	1.21	0.931	62.854	0	1.835	0.931	0.517	0.383	0.337	0.261	0.533
P2	I20	3.36	1.34	0.852	30.298	0	1.815	0.493	0.852	0.377	0.353	0.423	0.424
P2	I21	3.68	1.05	0.854	32.305	0	1.729	0.535	0.854	0.431	0.313	0.317	0.593
P2	I22	4.36	0.79	0.840	21.63	0	1.707	0.376	0.840	0.510	0.338	0.410	0.464
P3	I23	4.64	0.62	0.763	13.651	0	1.299	0.313	0.438	0.763	0.368	0.476	0.455
P3	I24	4.61	0.68	0.825	15.518	0	1.683	0.309	0.341	0.825	0.361	0.330	0.413
P3	I25	4.29	0.77	0.778	12.506	0	1.413	0.348	0.427	0.778	0.236	0.283	0.367
P4	I29	3.83	1.16				1.000	0.375	0.393	0.406	1.000	0.254	0.394
P5	I27	4.31	0.95	0.914	30.719	0	1.271	0.277	0.405	0.431	0.218	0.914	0.501
P5	I28	4.27	0.98	0.782	11.021	0	1.271	0.045	0.362	0.358	0.221	0.782	0.230
P6-7	I31	3.98	1.00	0.790	20.743	0	1.488	0.421	0.472	0.399	0.351	0.448	0.790
P6-7	I32	4.17	0.96	0.753	12.016	0	1.530	0.359	0.392	0.373	0.207	0.261	0.753
P6-7	I33	4.28	0.95	0.803	13.863	0	1.615	0.385	0.490	0.467	0.340	0.362	0.803
P6-7	I34	3.92	0.88	0.718	12.317	0	1.365	0.367	0.428	0.364	0.290	0.304	0.718

$N = 118$.
Shaded values in each column highlight the cross-loadings between items belonging to one scale (=OD-principle).

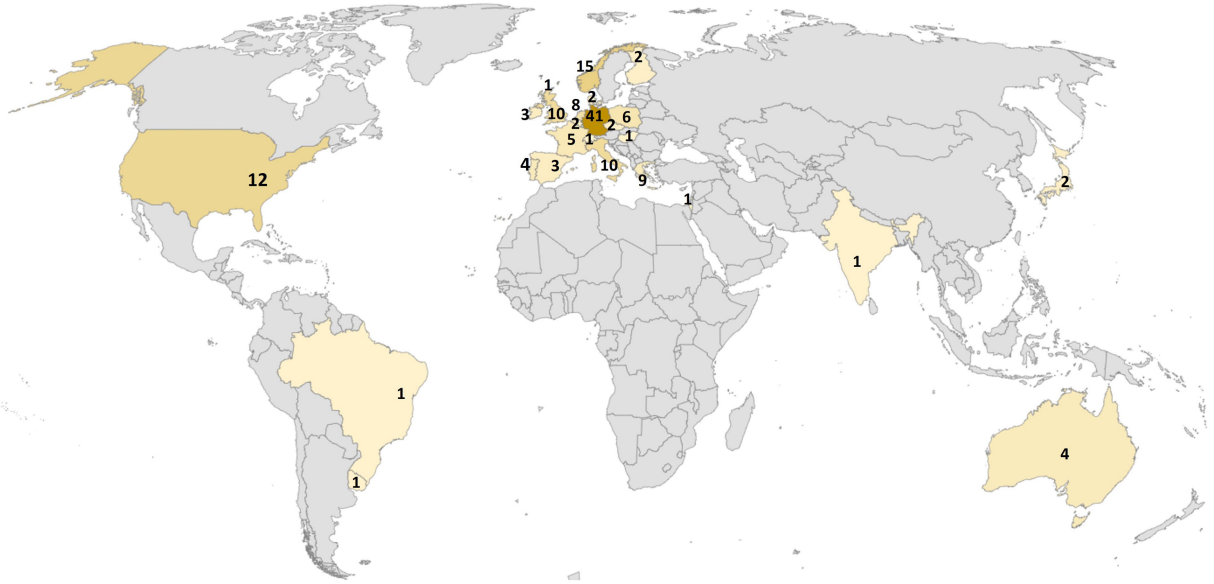

FIGURE 1
Global map of OD-Teams in mental health services responding to the HOPEnDialogue survey.

TABLE 2 Observed frequencies and percentages for sector, modality, and type of OD-service.

In which sector is your service?	Modality of services	Integration of services	*n* (%)
Non-public sector [Private- and Third sector (*n* = 45; 21%)]	In- & Outpatient (8)	Integrated service	6 (5%)
		Stand-alone service	2 (2%)
	Outpatient (37)	Integrated service	9 (8%)
		Stand-alone service	28 (24%)
Public sector (*n* = 73; 62%)	In- & Outpatient (34)	Integrated service	29 (25%)
		Stand-alone service	5 (4%)
	Outpatient (39)	Integrated service	27 (23%)
		Stand-alone service	12 (10%)

N = 118. Percentages appear in parentheses.

TABLE 3 Log-linear parameter estimates, values, and goodness-of-fit index for Service Sector, Service Integration, and Service Modality.

Effect	λ	*z*	*P*
[non-public sector] X [Standalone]	−1.885	−4.4858	<0.001
[Outpatient] X [Standalone]	1.715	3.622	<0.001
[non-public sector service]	−1.317	−4.531	<0.001
[Outpatient service]	0.028	0.119	0.906
[Standalone service]	−2.389	−5.180	<0.001

$G^2(2, N = 118) = 4.929$, $p = 0.085$.

specific effects reported in Table 3, however, are mostly significant and support the notion that the structural variables are importantly related (see Table 3).

We found that the odds of an OD-team belonging to integrated services were 3.73 times higher for OD-teams in public services than for OD-teams in non-public services. Furthermore, a significant association emerged with respect to OD-teams' Service Integration and Service Modality: the odds for OD-teams working in outpatient MHS not to work in integrated services was 5.71 times higher than for teams working in MHS with in- and outpatient services. The analysis proposes that OD-teams tend to emerge in organizational environments which are public, operate integrated services and offer both inpatient and outpatient services (see Table 4).

3.1.2. Access to OD-services and services' therapeutic context

Clients-referrals: Most respondents report referrals to OD-services occur via general practitioners (87%; 90/104); 61% (64/104) of the OD-teams reported referrals from hospitals, and 39% (41/104) referrals from social services. Some services report on established partnerships with associations sharing similar values (e.g., recovery groups) becoming OD-teams' primary referrals.

An important share of referrals to OD-teams reported are self-referrals: 46% (48/104) report referrals through "word of mouth" or direct requests as described in a comment by a respondent of the Finnish team:

TABLE 4 Partial associations for Service Sector, modality of service, and Service Integration.

Effect	Partial association X^2 (df = 1)	Sig. (*p*-value)
Service Sector * In-&Outpatient	3.445	0.063
Service Sector * Service Integration (Standalone vs. Integrated)	14.919	<0.001
In-&Outpatient * Service Integration (Standalone vs. Integrated)	8.449	0.004
Service Sector	6.708	0.010
Modality of Service (In-&Outpatient)	9.937	0.002
Integration	4.916	0.027

> *"Anyone can ask help for anyone (for themselves, for family members, for clients* etc.*) via phone, letters, walking to the office* etc. *Usually, people call the local service number (one number 24/7 for the whole region). Nurses on duty survey what the main problem is and when and where people want to meet (meetings can be arranged within 24 h, but usually, people/patients/clients want the first meeting to be arranged within 2–3 weeks from contact). Then she/he starts to arrange network meetings by calling workers from local outpatient clinics and/or other important people to join the process. Official referrals are not required, but they can be used as well."*

Clients-age groups: Almost all the OD-teams (93%; 110/118) work with clients aged 18–65; about 30% of OD-teams offer their services also to clients under 18 years of age, and about 43% of the OD-services reported an upper age limit of 65 years.

Clients-diagnostic profile: Most OD-teams work with clients with psychotic disorders (92%), mood disorders (86%), anxiety and fear-related disorders (81%), to a lesser degree on disorders associated to stress (64%), and other disorders (57%).

Therapeutic models mentioned in the OD-services besides the Open Dialogue approach are social psychiatry (10%) and recovery-oriented approaches (9%).

3.1.3. OD workforce

Hours of teams' OD practice per week: An average of 14.2 (Mdn = 10; SD = 12.4) hours per week was reported. 22% (19/87) reported more than 26 h per week of OD practice.

The median number of OD-trained staff members in OD-teams amounted to 14 (S.E. = 2.74) with a median of five members being trained in OD and a median of one member being in OD-training at the time point of study. 61% (72/118) of the teams offered their OD-service less than 20 weekly hours.

Table 5 reports the professional profile of the staff in OD-teams. Using chi-square test of independence, the professional profile of the staff differed significantly between teams operating in the public and non-public sector [$X^2(14;\ 1{,}604) = 407.793$; $p < 0.001$], with clinical personnel such as nurses (34%) and psychiatrists (11%) dominating the OD-teams in the public sector. On the other hand, we found that Support Workers (25%), Social Workers (19%) and Peer-support Workers (13%) dominate the professional profile in OD-teams operating in the non-public sector. Psychologists and

occupational therapists contribute equally to both sectors (see Table 5).

3.1.3.1. OD team taxonomy

To explore potential taxonomies of professional configurations in OD-teams, we ran a cluster analysis based on the standardized counts of professionals in each of the eight professional categories in 118 teams. Ward's linkage method with chi-squared distance metric was employed for the hierarchical clustering process. Missing values were treated as missing in the analysis.

The agglomeration schedule revealed that clusters were formed in 95 stages, with Ward's linkage coefficients ranging from 0.000 to 31.171. A dendrogram was utilized to visualize the hierarchical structure of the data clusters (see Supplementary Figure 2) and cluster membership for each case was saved in a new variable. Coefficients increased moderately from 16.987 to 17.659 to 18.463, and then took a much larger leap from 22.888 to 25.236, and then another jump from 27.993 to 31.171 which indicated a good cut-off point at 27.993 with four clusters of OD-teams based on the following professional characteristics (see Table 6):

- "Multi-professionals teams" ($n = 17$): are characterized by the highly heterogeneous professional profile in which 5–6 professions are on average presented;
- "Clinical Psy-Teams" ($n = 33$): are dominated by clinical professions (psychologists/psychotherapists, psychiatrists, and nurses) with a low degree of professional heterogeneity;
- "Teams with a prevalence of Nurses and Occupational therapists" ($n = 30$): are characterized by the highest share nurses, occupational therapists and peer-support workers;
- "Teams with a prevalence of Social workers" ($n = 16$): are dominated by the highest share of social workers (47%), a high share of nurses (23%), and it is the only group characterized by the absence of psychiatrists (0%).

Peer-support workers were represented equally in all clusters, with a share of about 10%.

Exploring whether the OD-teams with professional profiles differed in their OD-SA score, revealed that median scores were statistically significantly different between the different clusters [$\chi^2(3) = 13.816$, $p = 0.003$]: "Teams with a prevalence of Social worker" ($Mdn = 3.58$) scored statistically significantly lower on the OD-SA scale (OD-FID15) than "Multi-professional teams" ($Mdn = 4.20$; $p = 0.030$) and also lower than "Teams with a prevalence of Nurses and Occupational therapists" ($Mdn = 4.28$; $p = 0.002$) but not with respect to "Clinical Psy-teams" ($Mdn = 4.07$; $p = 0.146$). OD-teams composed of multiple professions yielded significantly higher OD-FID15 scores [$\chi^2(3) = 20.571$, $p < 0.001$; see Table 6].

3.1.4. OD staff training

1,192 staff members were reported to have taken recognized OD-training. Furthermore, 448 OD trainings were undertaken at the time of the survey, so a 38% growth rate of active OD practitioners could be projected for the upcoming years.

With respect of the share of OD-trained personnel in services:

- 4 = 26% ($n = 27$) of the OD-teams had all their clinical staff trained or undergoing a recognized OD-training program;
- 3 = 15% ($n = 16$) had only a small number of exceptions (e.g., a couple of members of staff who have recently joined, but are expecting to start training soon) not being OD-trained;
- 2 = 17% ($n = 18$) had most clinical staff completed or are undergoing a recognized OD training, and most of the remaining staff were due to be trained soon;

TABLE 5 Professional characteristics of the OD-trained workforces.

Items	Categories	$N = 118$	Percent of Cases	Public Sector ($n = 73$)	Non-Public (Private- & Third Sector; $n = 45$)
35. Current number of staff members (Professional profiles of OD-teams); $X^2(14; 1{,}604) = 407.793$; $p < 0.001$				$N = 1{,}035$	$N = 569$
1:	Nurses	439	27%	**353 (34%)**	*86 (15%)*
2:	Occupational Therapists	85	5%	57 (6%)	*28 (5%)*
3:	Peer-support workers	151	9%	*77 (7%)*	**74 (13%)**
4:	Psychiatrists	139	9%	**116 (11%)**	*23 (4%)*
5:	Psychologists/Psychotherapists	263	16%	**188 (18%)**	75 (13%)
6:	Social workers	271	17%	163 (16%)	**108 (19%)**
7:	Support workers	178	11%	*33 (3%)*	**145 (25%)**
8:	Others	78	5%	48 (5%)	30 (5%)
Number of staff in OD-Teams ($n = 72$)		$M = 19.83$; S.E. = 2.74; Median = 14.0;			
Caseload size currently ($n = 72$)		Median = 15.5;			
*Maximum caseload ($n = 72$)		Median = 30.0;			
*Number of Staff-training in progress ($n = 72$)		$M = 4.19$; S.E. = 1.63; Median = 1.0			
Number of OD-trained staff in teams ($n = 72$)		$M = 8.71$; S.E. = 1.37; Median = 5.0			

Categories significantly underrepresented are indicated in italic (adjusted residual < −1.96 at $p < 0.05$); categories significantly overrepresented are indicated in bold (adjusted residual > 1.96 at $p < 0.05$). *Median values of Maximum caseload and Caseload are in many cases based on subjective estimates only since (especially) public services in many countries are required to offer services as requested.

TABLE 6 OD-team taxonomy: Professional profiles of each cluster.

Professional profiles	Cluster: "Multi-Professionals team" ($n = 17$)	Cluster: "Clinical Psy-team" ($n = 33$)	Cluster: "Nurses and Occupational therapists team" ($n = 30$)	Cluster: "Social worker team" ($n = 16$)	All
Psychologists/psychotherapist	15%	**35%**	18%	11%	22%
Psychiatrists	11%	19%	9%	0%	11%
Nurses	17%	16%	**24%**	**23%**	19%
Social workers	12%	13%	11%	**47%**	18%
Peer-support workers	**11%**	8%	**11%**	9%	9%
Support workers	8%	5%	5%	3%	5%
Other professions	**24%**	0%	0%	2%	5%
Occupational therapists	3%	0%	**13%**	2%	5%
Prof. heterogeneity score (M) (SD)	**5.6**; 2.0	3.7; 1.5	**5.1;** 1.3	3.6; 1.6	4.5; 1.8
OD-FID15 (Mdn)	4.2	4.1	**4.3**	*3.6*	4.2

Categories significantly underrepresented are indicated in italic (adjusted residual < −1.96 at $p < 0.05$); categories significantly overrepresented are indicated in bold (adjusted residual > 1.96 at $p < 0.05$).

- 1 = 42% ($n = 44$) had less than half of the clinical staff with OD-training completed or were undergoing a recognized Open Dialogue training.

The item was scaled on a four point Likert scale ranging from 1 (less than half) to 4 (all their clinical staff trained) resulting in an OD-training level score ($M = 2.26$; $SD = 1.24$).

Responding to the question "Did the training include some self-work on participants' family of origin?" 45% ($n = 48$) of the teams reported having it included for all the practitioners trained; 13% ($n = 14$) for most; 12% ($n = 3$) only a few; and 11% for none.

Concerning the types of OD-trainings undertaken we report first (a) the percentage relative to the number of trainings and second (b) the percentage of teams who reported at least one member to have taken this training:

(1) 1-year "Open Dialogue practitioner foundation training"
   a. 80%; $n = 911$;
   b. 67% of the OD-teams.
(2) 3-years "Full Open Dialogue practitioner training":
   a. 12%; $n = 132$;
   b. 14% of the OD-teams;
(3) "Peer-supported Open Dialogue social network" (duration: 1 year):
   a. 8%; $n = 91$;
   b. 11% of the OD-teams;
(4) "Trainers' training program" (duration: 2 years);
   a. 4% ($n = 50$);
   b. 23% of the OD-teams;
(5) "International certification training in dialogic practice" (duration: 1 year):
   a. 1% ($n = 8$);
   b. 7% of the OD-teams.

To assess the OD-training level of teams, the number of training-years was divided by the number of trainings reported per team. On average, each OD-team was endowed with a mean of 1.1 years (S.D. = 0.72) of OD-training.

3.1.5. OD supervision and intervision

66% ($n = 78$) of the OD-teams reported having supervision in place to help clinicians reflect on and develop their OD-practice. 34% ($n = 40$) organize their supervision at least weekly, 25% ($n = 29$) at least monthly and 27% ($n = 32$) report supervision at least once every 3 months.

Supervisions include (1) mainly practitioner reflections (92%; $n = 65$) which (2) are in 73% ($n = 52$) of the teams observed and then reflected by other team members; (3) 58% ($n = 41$) of the teams include final reflections at the end of supervisions (e.g., original pair/group share a final reflection at the end); (4) 35% ($n = 25$) include a brief mindfulness practice during their supervision. We calculated a supervision score ranging from 0 (no supervision) up to five (supervision including all the four listed supervision activities) to measure teams' OD-supervision practice ($M = 3.05$; SD = 1.76).

Next, to supervision meetings, intervisions in the form of team meetings to reflect on Open Dialogue practice occur at least weekly in 28% of the teams; 33% report at least monthly meetings; 26% meet at least once every 3 months for this purpose.

3.1.6. Research capacity

20% of the OD-teams reported belonging to service including research and development units, and 68% collaborated with universities and external research institutions; 44% have already been involved in research programs.

Most OD-teams collected data about their clients' sociodemographic (e.g., gender, age), mental health (+95%), psychiatric history (86%), and medication (85%), and only 35% collected data on clinical routine outcomes. However, less than half of the teams used these data to evaluate clients' and/or carers' service satisfaction (46%) and service evaluation (47%).

Open Dialogue services reported (1) to be involved in audits (28%), (2) evaluations (32%), (3) quality improvement programs (47%) and (4) research programs (65%). A sum score ranging from 0 (not involved in any research or other systematic service evaluation programs) – 4 (all of the items) was calculated for the variable of teams' 'Research Capacity' ($M = 0.98$; $SD = 1.13$). The low mean value

reflects the data of 43% of teams (excl. 13 missing values) not being involved in any research or other systematic service evaluation programs (Score = 0).

3.1.7. Peer- involvement of experts by experience

In 56% ($n = 60/118$) of the OD-teams, experts by experience contributed to the OD-service. About 160 experts by experience were reported in this survey to practice Open Dialogue in these teams where they are primarily involved in the delivery of care (86%), development and planning (70%) and training as trainees (66%) in services. Less often, they are trainers in teams (46%) or engaged in evaluating and assessing services (43%).

48% of OD-teams recognize experts by experience formally in their role as paid workers of the service, while 11% of OD-teams report experts by experience to contribute to their services as volunteers. 44% are involved in supervision like other members of the team and 32% receive psychological support or dedicated supervision.

In 13% of the teams experts by experience participate in all network meetings; 41% engage them in reflections; in 35% join as support for the service user or family network, and in 30% of the teams they are involved as facilitators and moderators in meetings.

3.2. Exploring organizational antecedents of OD-self-assessment: partial least square multiple regression analysis

Zero-order correlations were computed to examine the associations between OD-services' characteristics and their OD-SA score (see Table 7). The following service characteristics were significantly positively correlated with teams' OD-SA Score: (1) Share of OD-Training in Staff, (2) Supervision for OD Practice, (3) Research & Evaluation, (4) Experts by Experience (EXBEX) involved in Supervision, (6) Teams' professional heterogeneity, and (7) Clients' self-referrals to services; negatively correlated were (8) Clients' average age groups (see Table 7) and remained significant as predictors in the multiple regression model. Fitting the regression model, two more items emerged as significant predictors: (5) the role of EXBEX as Facilitators, (9) Service Modality: Outpatient (see Table 8).

Exploratory partial least squares (PLS) regression analysis was used to identify significant predictors explaining the variance of teams OD-SA scores. The overall PLS-model for teams' OD-SA (operationalized via the 15 items score) was found to be statistically significant, $R^2 = 0.421$, ($R^2_{adj} = 0.384$; $p < 0.001$), accounting for 42% of the OD-SA measurement variance with a statistically significant model [$F_{(9, 108)} = 10.727$, $p < 0.001$].

- "*Share of OD-Training in Staff*" (see Section 3.1.4) was found to have a significant positive relationship with Teams' OD-SA, $\beta = 0.25$, $t(108) = 3.31$, $p < 0.001$. For every one-unit increase, the OD-SA score increased by 0.24 units, controlling for the effects of the other independent variables.
- "*Supervision for OD-practice*" (see Section 3.1.5) showed a statistically only moderate relationship with teams' OD-SA [$\beta = 0.17$, $t(108) = 1.94$, $p = 0.055$], holding all other independent variables constant.
- "*Research capacity*" (see Section 3.1.6) demonstrated a significant positive relationship with OD-SA [$\beta = 0.15$, $t(108) = 2.17$, $p = 0.032$].
- "Peer-involvement in OD-practice" (see Section 3.1.7) was not correlated with teams' OD-SA. However, one single item "*EXBEX involvement in supervision*" (4) was positively correlated [$\beta = 0.29$, $t(108) = 4.26$, $p < 0.001$] and one other "*EXBEX role as facilitator*" (5) was negatively correlated [$\beta = -0.26$, $t(108) = 3.78$, $p < 0.001$] with OD-SA.
- (6–9) four service characteristics emerged as significant predictors of teams' OD-SA: The *presence of multiple professions* in an OD-team (6) appeared to be positively correlated with OD-SA: $\beta = 0.20$, $t(108) = 2.35$, $p = 0.020$, so that the presence of one more different professions in OD-teams increases the OD-score by 0.20 points all other independent variables kept constant. Furthermore, the possibility of *Self-referrals* to OD-services is likely to increase its OD-SA by 0.14 [$\beta = 0.14$, $t(108) = 2.01$, $p = 0.047$]. Also, it appears that *clients' age-groups* to which OD-services are dedicated are negatively correlated to

TABLE 7 Means, standard deviations, and intercorrelations for OD-self-assessment (OD-SA) measure and OD-team characteristics predictor variables.

	M	SD	1	2	3	4	5	6	7	8	9
OD- self-assessment (OD-SA) Score	3.98	0.60	0.31**	0.38**	0.34**	0.24**	−0.15	0.26**	0.21*	−0.30**	0.11
1. Share of OD-Training in Staff (I50)	2.26	1.17	---	0.20*	0.17	0.05	0.08	−0.17	0.03	−0.09	0.08
2. Supervision for OD Practice (I51-2)	2.51	1.76		---	0.45**	0.12	0.1	0.25*	0.06	−0.17	−0.08
3. Research & Evaluation (I41)	0.98	1.06			---	0.13	0.12	0.35**	0.04	−0.04	−0.11
4. EXBEX involved in Supervision (I63)	0.79	0.31				---	0.25*	0.05	−0.01	0.17	−0.02
5. EXBEX: Facilitator (I62.1)	0.53	0.37					---	0.01	−0.03	0.07	0.01
6. Service: Team heterogeneity (I18)	4.45	1.58						---	0.01	−0.11	−0.21*
7. Service: Self Referrals (I12)	0.46	0.47							---	−0.11	0.06
8. Service: Clients' Characteristics: Average Age (I6)	40.64	6.93								---	0.05
9. Service: Outpatient	0.36	0.48									---

*$p < 0.05$; **$p < 0.001$.

TABLE 8 PLS multiple regression analysis summary for variables predicting OD-Teams' OD-self-assessment (OD-SA): $F_{(9, 108)} = 10.727$, $p < 0.001$.

OD-Self-Assessment	*B*	*SE B*	*B*	*SE*	*t*	*p*	*VIF*
1. Share of OD-Training in staff (I50)	0.13	0.04	0.25	0.04	3.31	0.001	1.15
2. OD-Supervision and Intervision (I51-2)	0.06	0.03	0.17	0.03	1.94	0.055	1.35
3. Research capacity (I41)	0.08	0.04	0.15	0.04	2.17	0.032	1.43
4. Peer involvement in supervision (I63)	0.57	0.13	0.29	0.13	4.26	0.001	1.12
5. Peers-role as Facilitator (I62.1)	−0.42	0.11	−0.26	0.11	3.78	0.001	1.09
6. Service: Teams' professional heterogeneity (I18)	0.08	0.03	0.20	0.03	2.35	0.020	1.29
7. Service: Self Referrals to services (I12)	0.18	0.09	0.14	0.09	2.01	0.047	1.02
8. Service: Clients' Characteristics: Average Age (I06)	−0.02	0.01	−0.24	0.01	3.59	0.001	1.10
9. Service: Outpatient service (I04)	0.21	0.09	0.17	0.09	2.37	0.020	1.06

$R^2 = 0.47$. $N = 118$. $p < 0.001$.

OD-SA [$\beta = -0.24$, $t(108) = 3.59$, $p < 0.001$], meaning that OD-services working with younger clients tend to operate more according to the seven OD-principles than OD-services working for older clients. Finally, OD-services operating as *outpatient services* appear to be slightly facilitated in their work according to the OD-principles [$\beta = 0.17$, $t(108) = 2.37$, $p = 0.020$].

The predictor scores of OD- self-assessment were projected into a scatterplot to identify OD-teams which may represent potential candidates for a mental health outcome study of Open Dialogue treatment (see Figure 2).

The scatterplot in Figure 2 offers a topological synopsis of OD-teams in four quadrants to capture the plausibility of the OD-SA scores.

1. Cases of "OD- self-assessment overconfidence" (see yellow quadrant above the regression in Figure 2): high self-assessment of OD-SA when conditions appear to be unfavorable. Here recommendations to work on OD-pillars such as training, supervision, research and/ or peer involvement may apply before outcome studies may be considered.
2. Cases of "OD-self-assessment sceptics" (see yellow quadrant below the regression in Figure 2): If all OD-pillars are in place, why is there a low OD- self-assessment? Further investigation is needed to better understand these cases.
3. "OD-inspired services": These are cases along the lower end of the regression (see red quadrant in Figure 2), which do have issues with the antecedent conditions to offer the OD approach (OD training, supervision, etc.) and self-assess their OD practices low.
4. "Candidates for outcome studies": these cases along the upper end of the regression (see green quadrant in Figure 2) appear to dispose of the favorable condition to provide OD practice and self-assess their OD-practice high. Considering the self-assessment nature on which these data are based, further assessment by independent evaluators might be needed to understand their current state of organizational and clinical practice prior to commencing an outcome study.

4. Discussion

The first achievement of this study was to develop, pilot and validate a scale for the self-assessment of mental health care services regarding the seven Open Dialogue principles. Our results demonstrated the construct validity of the measurement model, confirming the reliability of its subscales (OD principles) and their convergent and discriminant validity. However, further development is needed to improve the subscales related to Responsibility and Psychological continuity.

The empirical results of our global survey provide valuable insights into the characteristics and practices of OD teams across different countries. The results indicate a stable growth in OD-services over time (as indicated via the dates when they were first established), with a steady increase from five services in Finland and Norway in 2006 to over 100 centers in 2020 across 24 different countries. Geographically, the majority of OD-service centers were based in Europe, particularly in North European and Western European countries. This suggests that OD has gained significant traction in these regions, potentially due to cultural factors, research support, or policy initiatives promoting its implementation (e.g., Gooding, 2021; WHO TEAM – Mental Health and Substance Use, 2021).

The structural characteristics of OD services varied, with mental health departments and registered associations being the most common types of entities. Most OD-teams belonged to the public sector, while a significant portion belonged to the non-public sector. OD-teams operating in outpatient mental health services were more likely to work in integrated services compared to teams in inpatient services. This diversity in organizational settings highlights the adaptability and flexibility of OD within different healthcare contexts, which can help expand access to OD for a broader population.

Referrals to OD-services primarily came from general practitioners, hospitals, and social services, potentially indicating that OD is perceived as a valuable option by various stakeholders involved in mental health care. Self-referrals, through word of mouth or direct requests, also played a significant role. Furthermore, self-referrals reported by 46% of the teams were a positive predictor of OD-SA scores. The positive correlation between self-referrals and OD-SA scores suggests that individuals who actively seek out OD services may benefit from the approach, emphasizing the importance of client-centered care and empowerment. Furthermore, self-referrals may

FIGURE 2
Scatterplot of predictors of OD-self-assessment and teams' OD-self-assessment.

indicate the impact of OD-teams 'reputation' so that they are recommended by former clients or other professionals.

The survey findings confirm further that OD is utilized for a wide range of diagnostic profiles, with a particular emphasis (92%) on treating psychotic disorders. This aligns with previous research highlighting the positive outcomes of OD in this domain (Seikkula et al., 2003, 2011; Putman and Martindale, 2021). However, the survey findings also indicate the treatment of various other diagnostic profiles, indicating the versatility and applicability of OD beyond psychosis, which expands its potential impact on mental health care.

OD-teams worked with clients across different age groups ranging from minors (< 18) up to the elderly (+65). This suggests that OD is not limited to specific age ranges or diagnoses, indicating its versatility in addressing a wide range of mental health concerns. However, the significant negative correlation of OD-SA with client's age groups also indicates that teams working with younger clients tend to operate more in line with OD principles which might be associated with the fact that programs which address first-episode psychosis typically serve adolescents and young adults (Gidugu et al., 2021). Another explanation may be that older clients have usually been in the help system for a long time. This means that the private social network has usually already withdrawn and is more difficult to activate – bringing about low scores on the OD-SA scale according to the second principle of networking. Furthermore, the longer patients have been cared for, the more they might have become accustomed to professional care and the less socially inclusive ideas and steps come from the network itself. The latter may then lead to more action orientation of the team or through other care structures around the client.

Apart from a few services entirely organized with OD-trained professionals, the average number of OD-trained professionals involved in services is around 11.5, thus, representing primarily small OD teams. Moreover, only 22% of teams reported practising OD more than 26 h per week, which confirms that most professionals are practising OD alongside other approaches, with a risk of additional burden (Dawson et al., 2021). Depending on how different the treatment philosophy of the other part of the work is compared to OD, this can result in a real obstacle in the ability to maintain and keep a dialogical attitude. Furthermore, it needs to be better understood how some professionals can define specific times for "practicing OD" and times when they do not. This is in contrast with the Model in Western Lapland which is more alike a treatment culture and a way of arranging the entire service to guarantee dialogical responses to people's difficulties, rather than a specific method (Seikkula, 2013). Maybe this finding evidence challenges in defining what OD is, as well as mental health professionals' tendency to operationalize or view it as a treatment method/technique, when it may simultaneously lose some essential "healing" elements of care (von Peter et al., 2023).

The OD workforce consisted of professionals from various backgrounds, including clinical personnel (psychiatrists,

psychologists and psychotherapists and nurses), support workers, social workers, and peer-support workers. The professional profile of the staff differed between OD-teams operating in the public and non-public sectors. Cluster analysis identified four distinct clusters of OD-teams based on professional characteristics, showing that OD-teams composed of multiple professions had higher OD-SA scores compared to teams with a more specific professional composition. This finding is consistent with previous research emphasizing the value of interdisciplinary teamwork and the need for integrated care approaches (Montesano and Scherb, 2023). For instance, multidisciplinary mental health service models have demonstrated a positive impact in improving client engagement and communication among different specialties (Killaspy et al., 2009). Moreover, providers have indicated that various skills and perspectives contributed to increasing the range of solutions, with final benefits for the service users (Odden et al., 2019).

In terms of training, previous research has identified training costs and length as a barrier to implementation (Gordon et al., 2016; Florence et al., 2020), but there were no data available about the number and share of professionals in the teams participating in accredited training, which varies considerably according to the survey results. On the one hand, teams are practising OD with all (26%) or almost all (15%) of the staff have received accredited training and teams with most of the professionals trained (17%); on the other hand, there are as many as 42% of teams practising OD with less than half of the professionals trained. This clearly differs from Western Lapland, where most OD professionals have a three-year dialogical training (Alakare and Seikkula, 2021; Putman, 2021) whereas the most common training program reported in our survey was the 1-year "Open Dialogue practitioner foundation training." We also observed an indication of substantial growth since about 38% of staff members were still in training at the time point of the survey.

The survey at hand suggests that supervision is an important component of OD implementation as indicated by its near significant role as a predictor of teams' OD-SA scoring (see Table 8). Supervision activities reported in the survey included practitioner reflections, observations and reflections by other team members, final reflections, and mindfulness practice. Regarding frequency, 66% of OD-teams reported having periodic supervision in place to support clinicians in reflecting on and developing their OD-practice. However, 22% indicated no supervision, and 10% did not respond to this question. This lack of supervision can be particularly critical, especially considering the documented limitation in training level and percentage of professionals trained in the different teams. Challenges with OD supervision were already reported in previous studies (Hopper et al., 2020). Intervisions in the form of team meetings to reflect on OD-practice took place regularly had however no statistically significant impact on teams' OD-SA scoring.

Research and evaluation are an integrative part of the development of OD in Western Lapland (Seikkula et al., 2011), as confirmed in this survey, where their team represented an outlier on this topic. The mean score of international teams remains relatively low (0.98 on a scale from 0 to 4), since 38% of teams are not involved in any research or evaluation programs, and only a minority belonged to services with research and development units. Data collection focused on sociodemographic information, mental health and psychiatric history, medication, and to a lesser extent, routine clinical outcomes.

The survey findings indicate that experts by experience are involved in approximately 52% of the OD-teams surveyed. However, the extent of their involvement varied across teams. These experts are primarily engaged in the delivery of care, development and planning, and training within the services. Still, consistent with previous research (Bellingham et al., 2018), their systematic involvement in network meetings is limited, with only 21% of teams with experts by experience reporting their participation. The results also reveal that around 48% of OD-teams formally recognize experts by experience in their role as paid workers, while 11% rely on them as volunteers. Furthermore, we found contradictory results related to the impact of peers' involvement on OD-SA scoring. On the one hand, OD-teams in which experts by experience were involved in supervision were positively correlated with high scores on the OD-SA scale, underscoring the potential benefits of their inclusion in team dynamics. On the other hand, we found a negative correlation between the peers in the role of facilitators of network meetings and OD-SA scores, which would need further investigation and may be related to the difficulties of peers in accessing training compared to mental health professionals. Other possible interpretations could be the lack of role clarity that represents a barrier to establishing peer support (Crane et al., 2016), clinical hierarchies in mental health services (Razzaque and Stockmann, 2016), or the difficulty for peers to align with treatment routines that have been developed in a professional context (von Peter et al., 2021).

Finally, a major achievement of the study was to identify several organizational characteristics that significantly correlate with OD fidelity, including staff OD-training share, supervision for OD practice, research capacity, professional heterogeneity, self-referrals, outpatient services, and the involvement of experts by experience. These findings highlight the importance of these factors in promoting fidelity to the OD approach and suggest strategic areas for intervention and improvement to support OD implementation globally.

4.1. Limitations and recommendations for future research

The first limitation of the global survey is related to the sample's representativeness. In fact, despite our efforts to advertise the survey internationally, its reach may have been limited, potentially excluding certain regions or countries where OD is practised, such as Sweden and other teams in Norway. As a result, the findings may not fully represent the global landscape of OD teams.

The second limitation is related to the accuracy and the representativeness of the obtained results since only one member from each OD service has filled out the survey, and his/her view may have been different compared to other team members. Therefore, we recommend that future research include more perspectives and evaluations, inviting different stakeholders to assess the same service, similar to what Price et al. (2020) did in a different context. Moreover, as the survey relied on self-reported data, respondents may have been less accurate and positively biased (Martino et al., 2009) and provided socially desirable responses, either unintentionally or deliberately.

The third limitation is related to the fact that the survey employed a self-assessment scale developed specifically for the study. While efforts were made to ensure the statistical validity and reliability of the self-assessment scale, the items may not fully capture all dimensions of OD fidelity, or there may be conceptual limitations in how fidelity is measured and assessed. This could affect the accuracy of the self-assessment scores reported by the teams. Therefore, the questionnaire used can only be considered preliminary work for an OD fidelity scale validation study to be conducted according to standardized measurement methodology (i.e., Bond and Drake, 2020).

Finally, the survey is cross-sectional and based on quantitative data. This also implies that important information from OD services that are not active anymore are missing. We recommend future longitudinal studies to provide insights into the development of OD services over time and the use of qualitative investigations to gain a deeper understanding of the experiences and perspectives of OD teams, service users, and experts by experience and capture contextual information about the challenges and facilitators of implementing OD, including aspects that have not been assessed in the survey such as financial resources and team dynamics.

5. Conclusion

The survey findings contribute significantly to advancing the knowledge and understanding of the global development of Open Dialogue in mental health services. Also, indicating a growing number of OD services across different countries, the survey results demonstrate an increasing recognition of the value of OD in mental health care but also the urgent need for concrete actions to ensure its appropriate implementation.

Specifically, the global scoping survey can inform mental health policymakers and organizations to consider the following critical areas of intervention:

- Training: The survey highlights variations in OD training among professionals within OD teams, suggesting that mental health organizations and educational institutions should collaborate to develop and provide accredited OD training programs that cover various professional backgrounds and ensure a high level of competency among professionals delivering OD.
- Supervision: the survey reveals that many OD teams do not have regular supervision. As supervision plays a role in maintaining and improving fidelity, especially for teams at the beginning of their practice, mental health organizations and policymakers should provide support and resources for teams to engage in regular supervision.
- Research: the survey reveals that research and evaluation activities in OD are relatively limited globally. Encouraging and supporting research and evaluation in OD can contribute to the evidence base and help investigate OD interventions' effectiveness, cost-effectiveness, and outcomes. Mental health organizations, funding agencies, and researchers should prioritize research on OD, promote collaboration among international research teams, and allocate resources for rigorous evaluation studies to build a stronger evidence base, not only on psychosis.
- Involvement of experts by experience: the survey findings suggest that involving peers in OD supervision positively correlates with OD-SA scale, highlighting the importance of meaningful involvement and engagement of service users in delivering mental health services. However, the findings also indicate potential difficulties for peers to facilitate network meetings in adherence to the OD-principles. Mental health organizations should actively support the participation of experts by experience in training and supervision to overcome this difficulty in their involvement.
- Mental Health Settings: the survey findings indicate that OD is primarily practised in outpatient settings and focuses on the treatment of psychosis. Mental health organizations should explore opportunities to integrate OD principles and practices into other mental health care settings, such as inpatient units, community clinics, and primary care settings. This expansion would allow a broader range of individuals with mental health needs to benefit from OD's person-centered and dialogical approach.

Finally, the survey highlights the geographic concentration of OD services in certain regions, particularly in Europe. There is a need to promote collaboration and knowledge exchange among OD teams globally to share best practices, experiences, and research findings.

Data availability statement

The datasets presented in this article are not readily available because data would identify the participating entities. Requests to access the datasets should be directed to Raffaella.Pocobello@istc.cnr.it.

Author contributions

RP was involved in all the research process. TeS contributed to developing the questionnaire, data analysis, writing, and interpretating results. FC contributed to the literature review, data entry, writing, and interpreting results. MA-M, TB, SeP, MH, VA, StP, and JS contributed to the development of the questionnaire, the interpretations of the results, and reviewing the final version of the manuscript. All authors approved the submitted version of the article.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1241936/full#supplementary-material

SUPPLEMENTARY FIGURE 1
Historical development of OD-services in different countries from 1990–2022.

SUPPLEMENTARY FIGURE 2
Dendrogram of the cluster analysis using Ward linkage.

SUPPLEMENTARY DATASHEET 1
HOPEnDialogue-Survey Questionnaire 2020.

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Implementation of open dialogue in Germany: Efforts, challenges, and obstacles

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Purpose: The Open Dialogue (OD) approach has been implemented in different countries worldwide. OD not only depends on therapeutic principles but also requires a distinct set of structural changes that may impede its full implementation. In Germany, OD is currently practiced in different mental health care settings across the country. Yet, full implementation of OD principles is limited due to the extreme structural and financial fragmentation of the German mental health care system. With this as a background, the aim of this study was to investigate the efforts, challenges and obstacles of OD implementation in Germany.

Methods: This article presents the German results from the international HOPEnDIALOGUE survey, supplemented with expert interview data. Thirty eight teams currently providing OD took part in the survey. Sixteen expert interviews were carried out with stakeholders from various care settings. Survey data were analyzed descriptively and the qualitative data were evaluated using a thematic analysis approach.

Results: While having to adapt to the fragmented German health care system, OD has been mainly implemented from outpatient service providers and stand-alone services. About half of the teams implemented OD under the conditions of cross-sectoral model contracts and, thus, are considerably limited when it comes to OD implementation. Altogether, OD is not implemented to its full extent in each of the institutions surveyed. Similarly, the expert interviews revealed various challenges that mainly relate to the realization of OD's structural principles, whereas the implementation of its therapeutic benefits remains less affected. However, these challenges have managed to lead to great commitment by single teams and a certain level of implementation of OD-related concepts.

Conclusion: OD in Germany can currently only be fully implemented under the cross-sectoral care model contract system that is often temporary, thus significantly hindering its continuous development. Any evaluation of OD's effectiveness in Germany thus needs to take into account the fragmented nature of the country's health care system and control for the multiple barriers that impede implementation. Reforms of the German health care system are also urgently needed to create more favorable conditions for the implementation of OD.

KEYWORDS

Open Dialogue approach, implementation, mental health care, crisis, Expert interviews, need-adapted, fidelity

Introduction

Open Dialogue (OD) is an integrated approach of continuous community-based and multiprofessional psychiatric support in severe crises, originally developed in Western Lapland, which involves the social network of service users from the very beginning. The central (therapeutic) element are network meetings with the users and their environment with the aim of promoting dialogue in the network, enabling mutual understanding of the respective perspectives on the current situation, and empowering clients and their networks to make joint decisions for further actions and desired changes. All other therapy services, e.g., individual psychotherapy, social work, etc., are provided and integrated as needed. In the original model, this explicitly also refers to the handling of medication, which is often only used selectively and after joint consultation due to the safeguarding framework of joint network meetings (Seikkula et al., 2006). Accordingly, OD is seen as an important and promising approach to a more person- and recovery-oriented and rights-based mental health care (Von Peter et al., 2019, 2021; WHO, 2021).

The OD model essentially consists of a community-based treatment structure as well as a specific dialogic conversation approach and is often described in terms of seven basic principles (Aaltonen et al., 2011; Seikkula et al., 2011): 1. Immediate help in crises, ideally within 24 h; 2. Involvement of the social network through network meetings from the beginning of the treatment; 3. Flexibility and mobility with regards to the needs of the network in terms of frequency, location and participants in network meetings; 4. Responsibility for the organization and implementation of the entire treatment process by the treatment team; 5. Psychological continuity or ensuring the continuity of relationships and common understandings over the entire course of treatment; 6. Tolerating uncertainty during network meetings and the entire treatment process and 7. Promoting dialogue and polyphony between network members as well as the staff members.

Since its development, different cohort studies have shown promising results in clinical, economic and social outcomes (Seikkula et al., 2006; Aaltonen et al., 2011; Seikkula et al., 2011; Bergstrøm et al., 2017; Bergström et al., 2018). This has led to the recognition and dissemination of OD worldwide (Buus et al., 2021). Currently, OD has been adapted and at least partially implemented in 25 countries (Pocobello et al., 2022), although it should be noted that the original practice of progressively withholding neuroleptic treatment for people experiencing first-episode psychoses has been implemented so far only in Western-Lapland and nowhere else in this world. Concerning the implementation, various obstacles have been described, related both to OD structural and therapeutic principles (Buus et al., 2021). A recent interview study mentioned, for example, that OD is not a "manualized" treatment method, explaining why this may generate tensions in organizational implementation that "favor specific and standardized practices" (Lennon et al., 2022). In another ethnographic study, the core values of OD are described as being in conflict with the "expectations of professional practices and performance" (Dawson et al., 2019). Moreover, it has been reported that adopting OD, like any other organizational change, may generate "organizational, professional, and personal resistance" (Søndergaard, 2009).

Thus, and in spite of this, OD may be adapted to different contexts (Seikkula and Arnkil, 2006) and should be adjusted to local conditions, while knowing that its implementation will encounter various obstacles and challenges. This stems from the fact that the OD approach is not only a particular intervention or a specific form of therapeutic conversation, but also requires certain changes on the structural and organizational levels to be implemented (Seikkula and Arnkil, 2006; Haarakangas et al., 2007). Thus, the success of its implementation depends on the specific conditions of the contextualizing health care systems, strongly affecting the realization of its structural and therapeutic principles (Seikkula et al., 2001), which are often adapted to suit local conditions (Buus et al., 2021). For these reasons, the following section presents some facts and structural details of the German mental health system that are needed to understand the subsequent results of our study. The main research question, which obstacles and challenges hinder the implementation of OD to its full extent makes it necessary to address some of the financial and structural specifics of the German mental health care situation.

1.1. OD in the German mental health system

In Germany, OD has met with a great response and many providers of (community) psychiatric care have had their staff trained further and have also oriented their range of services to include OD (Steinert et al., 2020; Von Peter et al., 2020). Since 2007, 77 Open Dialogue trainings have been conducted with about 30 participants each, mostly made possible through the commitment of one of the authors (VA). In close cooperation with the training groups, a curriculum has been developed (Aderhold and Borst, 2016), resulting in a training program over 16 days (8 workshops) that is compatible in terms of time and economy for providers of psychosocial care. Besides theoretical inputs, it is largely focused on staged exercises and self-experience for each key element and full-length coached role plays of network meetings through identification with own clients. With the aim of networking among different service providers, the

workshops were either conducted with participants from several providers in a region or as in-house training, often with participants from other regional cooperation partners, mostly several courses in a row. In addition, course graduates were increasingly included as co-trainers after they had gained sufficient practical experience in conducting network meetings. In this way, more regional co-trainers were soon available, and regional trainer networks have since been formed for further training.

However, despite this great commitment, a full implementation, especially of OD's structural principles remains limited due to the structural and financial fragmentation of the German health care system. Currently, routine psychiatric care financed by health insurance schemes is mainly provided by psychiatric inpatient or outpatient clinics and office-based psychiatrists or psychologists. These are supplemented by a broad spectrum of nonmedical, residential, occupational, rehabilitative and other psychosocial services (Salize et al., 2007), financed by other cost units like pension funds or taxes. In the absence of a comprehensive national policy on mental health, this fragmentation of service providers and payers leads to large regional disparities in the variety of offer, content and quality of services (Bramesfeld et al., 2012) and, even within one region, services are often poorly integrated. In particular, the transition between inpatient and outpatient care is often not well coordinated and the risk of discontinuity of care during this transition process is quite high (Puschner et al., 2012). Accordingly, intensive outreach community mental health care programs (e. g. ACT, CRT) have rarely been implemented in the German psychiatric care system despite the national and international evidence of their effectiveness (Gühne et al., 2018; Von Peter et al., 2019), except from some innovative financing frameworks that have emerged within the past few years. Since 2013, so-called "model projects" (§64b, SGB V) have made it possible to further develop hospital-based yet cross-sectoral mental health care approaches, leading to more needs-based care and support and a diversity of approaches with home treatment (Bauer et al., 2016). Moreover, since 2007 the so-called "integrated care" according to §140a (SGB V) offers the opportunity to integrate different service sectors and interprofessional treatment groups, thus improving the continuity and quality of care mainly in the outpatient sector (Schwarz et al., 2020). Both projects use *model contracts* apart from the regular funding system for testing new forms of service structures and thus are limited either in scope to certain users or health insurance companies, as well as in terms of treatment and contract duration.

Given this context, there is currently no regular funding that better enable a person-centered, needs-based, and cross-sectoral mental health care approach and thus allowing for more comprehensive implementation of OD (Von Peter et al., 2020). Thus, an OD-related support could only be provided under the limiting conditions of standard care or in the context of limited model contracts. Accordingly, the first trainings were conducted only in services without regular funding (e.g., integrated care). As this practice became better known, trainings in regularly funded structures were added, in the hope of slowly 'eroding' the overall system and knowing that only a partial implementation would be possible. And in terms of concrete treatment pathways, this means that patients can only receive OD-oriented treatment at selected facilities. Within regular care, largely in clinics without the capacity for early outpatient care and limited to a short treatment period. And within model projects, often for longer periods, but limited to individual health insurers and not for clients in acute crises.

1.2. Aim of the study

Against this background, it is of great interest to uncover to what extent the OD approach can currently be implemented in Germany. The aim of the present study was to evaluate the status of implementation practices and fidelity to the OD principles. In addition, the specific challenges and obstacles that make OD implementation and realization difficult under the current conditions of the German mental health care system were investigated in more detail.

2. Materials and methods

This article presents part of the results of the HOPEnDIALOGUE online survey [the procedures and main results will be presented in a dedicated article (Pocobello et al., 2022)], an international collaborative multicenter study investigating the implementation and effectiveness of Open Dialogue in different countries/contexts (www.hopendialogue.net). The survey was completed by expert interviews on the specific efforts, challenges and obstacles of implementing and practicing OD within the German mental health care system. This allowed us to use a two-fold research approach, with the survey giving an overview of implementation status in Germany and expert interviews providing for an in-depth understanding of the related problems and challenges. The online survey was conducted from February to September 2020, followed by expert interviews from September to November 2020.

2.1. Materials

As part of the first phase of the HOPEnDIALOGUE project, the online survey was conducted to emphasize the number of OD-providing services worldwide and the extent of implementation. For this purpose, a questionnaire consisting of 65 items was developed by the HOPEnDialogue research group, covering different topics (e.g., general information on the facility, information on the OD service provided and level of fidelity of OD) (Pocobello et al., 2022). Most of the questions included single-, multiple-choice and free-text responses. Fidelity to the principles of OD was measured with 18 items on a 5-point Likert

scale ("never" – "almost always"), each of which was phrased as a statement about compliance with an OD-principle to provide a service (e.g., "The first meeting takes place within 24 h after the request for help."). We translated the original version for the German survey and added 12 further questions that specifically related to the German context (e.g., the financial framework conditions and the reasons for implementation). The survey was freely accessible and self-administrated using UniPark EFS Survey (Tivian XI GmbH, Cologne, Germany).

The expert interviews were conducted to gain a deeper understanding of what helps and what impedes the implementation and practice of OD within the German health care system. The interview guide was developed in four stages according to Helfferich (Helfferich, 2011). First, some of the authors (MB, HT, SvP) developed the questions on the object of the study, incorporating existing knowledge of OD and based on other models of health services research (Proctor et al., 2009; Brooks et al., 2011). These questions were then checked for fit and duplication and discussed with the rest of the research team (KH, MK, VA). The questions were then sorted and clustered into thematic interview sections, and a guiding question was formulated for each of these sections. In this way, the finalized guide emerged covering three thematic sections: 1. implementation process and implementation practice in the respective institutions, 2. comparison between the model and the actual implementation and 3. interests and hopes for maintaining and further developing the OD services offered. Using the format of an open interview, a theory-practice comparison was also discussed using a list of OD principles. The full interview questionnaire can be found in electronic annex to this publication (Supplementary Table 1).

2.2. Recruitment

The recruitment for both the qualitative and standardized assessments was done in collaboration with the Open Dialogue Network in Germany, a self-organized association of professionals and interested parties who practice Open Dialogue, offer training and/or are committed to the practice's dissemination in Germany (Von Peter et al., 2020). Through this network, we had a fairly reliable overview of all institutions in Germany offering OD in their services. This allowed us to aim for a full survey of 43 inpatient and outpatient facilities that, to our knowledge, were offering OD-inspired services at the time of the study. Teams with individually trained staff members but where OD practices were not a relevant part of services offered were not included.

To recruit for the online survey, the study was advertised in advance during the bi-annual meetings of the network and a list of all potential facilities was compiled. When the study began, an invitation to participate was sent, asking for completion of the survey by a team member with leadership responsibility on behalf of the entire facility or OD-Team. Reminders to participate were sent again at 3- and 6-week intervals.

Participants for the expert interviews were also recruited as a subsample of the survey participants with the greatest possible heterogeneity in terms of age, gender, profession, professional experience, and the settings/conditions in which they practice OD. Staff from institutions where the survey results had showed extensive implementation practices were included, as well as staff working in institutions with rather low levels of OD implementation. The interviews lasted an average of 90 min (range: 55–148 min.).

2.3. Analysis

Survey data were mostly evaluated descriptively. The characteristics of the facilities partaking were summarized in absolute and relative frequencies. The degree of implementation based on the fidelity items was illustrated in relative frequencies depending on the different response options. An exploratory analysis of potential differences in the various fidelity items between facilities with different service focus and funding was conducted non-parametrically using Mann–Whitney-U-Tests. The significance level was set at 5% (two-sided).

The qualitative data from the expert interviews were evaluated using a thematic analysis approach and using MAXQDA Software (VERBI Software, Berlin, Germany). Categories were formed both inductively based on the interviewees' response material, and deductively in light of OD principles (Seikkula et al., 2001). Each transcript was coded twice (by HT and MB) to increase reliability. Codes were discussed and agreed upon in a subgroup of the research team (HT, MB, SvP). For the purpose of this publication, the code tree was revised and adapted (by KH) to select suitable material that reflects the survey data. As a result, not all categories are reported in this article. The complete category system is available from the authors upon request.

3. Results

The survey results are presented first, followed by data from the expert interviews that provide detailed insight into the specific challenges and obstacles to implementing OD in Germany.

3.1. Survey data

Out of a total of 43 facilities and teams practicing OD which were contacted, 41 from almost all of the federal states participated in the survey (response rate: 76.7%). If more than one team from one and the same institution were practicing OD under different framework conditions, they took part as separate teams in the survey, which occurred in 6 cases. Due to incompletely filled out questionnaires the data of three OD-teams had to be excluded. In the end, this resulted in 38 data sets of teams that were included in the evaluative analysis. Although the overall survey data was extensive, only the data on the implementation of and fidelity to the

OD principles that fit the research questions are presented below. First, the characteristics of the OD institutions are described in more detail, followed by a description and analysis of the fidelity to OD principles by these institutions.

3.1.1. Implementation of OD in Germany

Table 1 provides an overview of the structural characteristics of all the participating institutions: in all cases, the majority of OD teams were outpatient service providers under public/non-profit ownership. Half of the teams offer OD under cross-sectoral model contract funding conditions. Among them, the hospital-based services, which are mostly responsible for acute treatment in Germany, offer OD exclusively under these model conditions. Moreover, in 47% of participating facilities, funding innovations, such as cross-sectoral model contracts described in the introduction, were the triggering factor to start the OD implementation process, which again highlights the importance of structural preconditions for this to occur.

By the time of the survey, the OD services in the participating facilities had existed for an average of 6.1 years (SD = 5.1), demonstrating rather recent implementation. The time between the first preparatory work and the first network meeting was 1 year on the average (SD = 1.2), showing a rather short implementation duration. In most cases, the first impulse for implementation came from the mid-level (30.9%) or senior management level (54.8%). In a good 45% of the facilities, almost the entire staff had been trained, but in another 45%, less than half of the staff received OD-training. The majority of the OD-practicing employees were social workers and nursing staff and in 66% of the facilities, peer support workers were members of the OD team.

3.1.2. Fidelity to OD principles

Figure 1 shows the self-assessed extent of implementation of the OD principles across all participating teams, as assessed using the operationalization of the HOPEnDIALOGUE survey (except for one additional item). 71.1% of the facilities reported that they are rarely or never able to offer a network meeting within the first 24 h, and 44.7% declared that such an offer was not possible within the first week of treatment. 42.1% of the teams do not regularly offer network

TABLE 1 Characteristics of OD providing facilities/teams in Germany (*N*=38).

N		38	
Service structure		***n***	**%**
Sector	Public/nonprofit	29	76
	Private	9	24
Service focus	Outpatient	22	58
	Inpatient	0	0
	Both	16	42
Service integration	Stand-alone (versus integrated service)	24	63
Treatment responsibility for catchment area		24	63
Open 24 h		14	37
Legal framework (funding) for OD[1]	Cross-sectoral model contracts (§64b, § 140a)[2]	20	53
	Standard care contract	19	50
OD service structure			
Trained staff	(Almost) all	17	45
	Majority	9	24
	< 50%	17	45
Reasons for implementation[1]	Dissatisfaction with current service	19	50
	Strengthening of caregiver support	18	47
	Change of funding model	17	45
	Practical experience in OD	11	29
	Strengthening the psychotherapeutic orientation	11	29
	Improving cooperation among colleagues	9	24
Clients' age[2]	<18	8	21
	18-65	38	100
	>65	27	71

[1]multiple answers possible.
[2]"model contracts" via "model projects" according to §64b, SGB V and "integrated care contracts" according to §140a, SGB V.

FIGURE 1
Extent of implementation of the OD principles across all participating teams, self-assessed with the HOPEnDIALOGUE survey. *additional item for the German examination.

meetings for all their clients and 26.3% do not provide an entire treatment process together with the clients and their networks. Finally, about 50% rarely or never offer their clients more than two network meetings in total, drawing on an item that had been added to the survey only at the German research sites.

On the other hand, when network meetings do take place, the majority of the teams design the meetings according to the needs of the participants, both in terms of content (100%) and location (84.2%). The same applies to the amount (78.9%) and type (92.1%) of interventions regarding the entire treatment beyond network meetings. In addition, most of the teams appoint one dedicated staff member to coordinate the whole treatment process for clients (100%) and form a consistent team for the entire treatment process (86.8%). Regarding decision-making processes, 68.4% of the teams try to

prevent early decisions on the treatment plans and 47.4% tend to discuss them openly during network meetings.

With regard to a potential interrelation with the financial and structural framework conditions, there were almost no statistically significant differences in the estimated fidelity to the various items on OD principles between facilities with different funding conditions or between inpatient and outpatient services. The only difference was that facilities with cross-sectoral model funding under §64b or §140a SGB V, were able to offer their clients 3 or more network meetings, i.e., significantly more often than those without ($U = 148.5$, $Z = -2.298$, $p < 0.02$). The same applies to teams without the treatment responsibility for a particular catchment area compared to teams with such responsibility ($U = 142.5$, $Z = -2.201$, $p < 0.028$).

3.2. Expert interview data

To understand the obstacles and challenges of OD implementation in more depth, expert interviews were conducted with 16 clinicians working in OD services in different contexts. The mean age was 49.56 years (SD = 10.85), and participants had an average work experience of 21.06 years (SD = 10.89). Moreover, they differed in their occupational groups and working contexts (see Table 2).

To facilitate a comparison between the results of the survey and the interviews, the obstacles to OD fidelity are presented first followed by a more comprehensive description of implementation challenges that are summarized under three levels of complex systems (macro-, meso- and micro-level) for the sake of clarity.

3.2.1. Obstacles to implementation Fidelity

Different levels of fidelity to OD principles were also evident in expert interviews. Many participants reported that their teams offer flexible, continuous and mobile treatment, but this applies rarely to network meetings or "emergency-related" support:

> "There are people who we see for half an hour a week, and there are people that we visit for two to three hours, three times a week. But I honestly wouldn't say that is because of Open Dialogue, but because of the way we work in our outpatient setting." (participant 9, social worker)

> "[…] we ask [the patients] where they want the network meetings to take place, and most of the time it's at home. Sometimes they prefer to come to the hospital. And we've also held network meetings in a café or something." (participant 4, psychiatrist)

Providing immediate help was seen in most cases as impossible, as the majority of the facilities offer no crisis services whatsoever. Instead, immediate or initial contact is made possible within the first 24 h *via* telephone or emergency hotlines that had been set up for this purpose. In a few teams, where meeting personally within 24 h was considered possible, this mainly concerned individuals, as network meetings would hardly be possible to organize within such a short time frame:

TABLE 2 Characteristics of respondents interviewed (n=16).

		n	Ø	SD
Total		16		
Female		11		
Age (years)			49.56	10.85
Work experience (years)			21.06	10.89
Profession	Nurse	2		
	Social work/education	6		
	Psychology	4		
	Medicine	3		
Type of Service[1]	Outpatient crisis service	7		
	Residential Care	6		
	(day) Hospital	5		
Legal framework[1] (funding)	Cross-sectoral model contract (§64b, § 140a)[2]	9		
	Standard care contract	9		

[1]multiple answers possible.
[2]model contracts via "model projects" according to §64b, SGB V and "integrated care contracts" according to §140a, SGB V.

> "We don't provide immediate help, that's not what we offer. I have already considered offering network talks in crisis situations. But we haven't managed it yet." (participant 3, social worker)

> "Immediate help in case of a crisis, that's already quite a juggling act [...] especially when our whole day is already filled with appointments." (participant 5, psychologist)

Even beyond situations where immediate help would be needed, many interviewees regarded regular network meetings as "impossible," despite the fact that network orientation was seen by all interviewees as a significant part of their care work:

> "We strive for network meetings, but realization is not always possible or desired." (participant 14, psychologist)

3.2.2. Challenges at the level of the mental health care system and policy (macro-level)

At the level of the health care system, a number of "structural problems" were described that make implementation of OD difficult. In particular, the fragmented nature of the German mental health care system results in a situation of numerous and often blurred treatment responsibilities:

> "[…] you have to be careful, if the patient has an outpatient neurologist, an outpatient psychotherapist, then it is again difficult [to ensure] that there is no overlap in care." (participant 11, psychiatrist)

> "[If] someone calls [...] I'm not allowed to do anything. I always have to send them to the local health authority, so

> that they come to us after this control round, so to speak, and only then I am allowed to [start treatment]. So, this whole crisis thing only works from the moment the client is already part of our system." (participant 12, nurse)

As a result, reacting quickly in the case of first contact is often very difficult or impossible, a situation that is also related to unclear or non-existent funding:

> "[...] having a team [...] come within 24 hours […] is not possible due to the health care systems and the contracts we have." (participant 2, social worker)

> "A quick response is not possible as we must first clarify the health insurance's coverage of the treatment." (participant 2, social worker)

Moreover, some financial frameworks only allow for a quite restricted range of options, instead of providing for needs-oriented, continuous, and flexible support:

> "These two staff members will stay only as long as the insurance contract lasts. That is only possible for three years." (participant 2, social worker)

> "The contracts we have with the health insurance companies basically determine how much money we get per client per year. They change the amounts again and again, which has lowered payments, and made eligibility criteria higher for clients. As a result. we were supposed to provide the same care with less and less money, which made it difficult to say: "We'll […] still work in pairs, we'll still go to people's homes, we'll still have network meetings." That has definitely made it more difficult for us." (participant 2, social worker)

More concretely, these inadequate financial conditions result in a lack of resources in time and staff to provide OD sufficiently with its different aspects. As the German health care system provides resources only for the treatment of individuals, involving his or her social network is not covered by insurance. This also applies to the additional time needed to organize network meetings and other administrative tasks related to implementation of the OD approach:

> "We do not meet regularly in the patient's home environment. We don't have the time for that. We meet too many people during the day for that." (participant 5, psychologist)

> "[…] we only have limited time resources, which […] makes it not so easy to design a long-term treatment process." (participant 7, nurse)

> "You end up faced with limitations in terms of personnel, of course. You can't even manage to have a [...] reflective team of several people there. [...]" (participant 5, psychologist)

> [The] "organization is an obstacle [...] we have relatively little time for the clients [...] there is simply a lot of administrative stuff to do around it." (participant 12, nurse)

Lastly, difficulties with implementing OD were mentioned that are the result of the health care system's focus on outcomes and solutions, instead of processes:

> "This goal-orientation, which is prevalent everywhere, means that we have to formulate goals and then work furiously to achieve them; this sometimes makes it difficult to remain in the here and now." (participant 7, nurse)

3.2.3. Institutional obstacles (meso-level)

Structural deficiencies were also reported at the level of the individual facilities. Many interviewees expressed their wish for a more substantial structural integration of OD work across their various facilities. In their opinion, this would only be possible if other treatment offers are discontinued and a change of attitude happens:

> "We had to give up some of the old ward structures. Simply to be able to react more flexibly. Network meetings are quite time consuming and in order to guarantee we have enough time, we have reduced the number of treatment groups." (participant 4, psychiatrist)

> "What makes it more difficult are the traditionally designed structures. […] there is still little idea that psychiatry can also be done differently." (participant 16, psychologist)

Accordingly, some interviewees wished for more understanding of the OD method within the entire institution. They especially stressed the importance of a sufficient number of trained employees to ensure that implementation did not fall on too few shoulders:

> "It needs a critical mass, which is what I said earlier. It is always difficult when staff members are alone in the facilities […]. At the same time, it is important to bring along the others who have not done the training, but who need to know what is going on, so that they do not have the feeling that this whole story is passing them by." (participant 1, psychologist)

In this aspect in mind, the high turnover of employees was deemed problematic, especially in hospital environments, where staff continuity is a problem anyway:

> "What continues to be a fundamental problem, of course, is staffing. In general, […] there is simply a lot of change at all levels. A lot of inconstancy. Especially in the nursing sector, due to shift work, part-time staff, absenteeism. That is certainly the biggest challenge to create a minimum amount of continuity." (participant 2, social worker)

The lack of integration within an institution was also perceived to be related to a lack of support from the management level. A greater commitment and understanding coming from this level was desired in order to facilitate the OD implementation process. Participants objected to a primarily economic interest on the part of management, which was reflected in job cuts, among other things:

> "uh, they have always been struggling and, in my opinion, this was due to the [...] inadequate support by management level." (participant 7, nurse)

> "It only works when the leaders are on board. They don't have to undergo the training themselves, [but] they must have knowledge of Open Dialogue [and] there has to be a commitment. [...] Part of the implementation must be top-down." (participant 1, psychologist)

> "There is always the threat of job reduction. I also have the impression that the hospital management […] does not look at what patients need, but only at what they can make money with. […] And of course, Open Dialogue suffers from this, because it is a bit more personal and time-consuming than just prescribing medication." (participant 11, psychiatrist)

In the view of many interview participants, cooperation with providers of other mental health and social services is also impaired by the lack of financial capacities to include treatment facilitators from outside of the institution:

> "When we organize a network meeting, we ask the client's psychiatrist to leave her practice and come to our facility and sit down for two/three hours. On a financial basis, that is simply impossible." (participant 1, psychologist)

Moreover, too little dissemination of OD in other services and a lack of communication among practitioners within the region often lead to low visibility and understanding of this approach:

> "It has certainly made it more difficult that there is no networking with other institutions that also do this." (participant 3, social worker)

> "What we would need, is a utopia: broader implementation in the regional care system, so that others know what we are talking about when we invite people to a network meeting." (participant 1, psychologist)

3.2.4. Individuals' resistances and reservations (micro- level)

At the day-to-day work level, participants primarily pointed to resistances or reservations about the OD approach as a further obstacle. In some interviews, a degree of "innovation fatigue" due to the constant introduction of new concepts in psychiatry was mentioned to explain this:

> "New things are always coming onto the market and then they are hyped to the point of no return, and at some point, they fall apart and then the next one comes along. That's rather counterproductive and makes many people skeptical." (participant 7, nurse)

> "I had a conversation with a manager from another facility. He told me: 'I have supported so many supposedly promising projects over the last years and invested so much time in them, and it has often come to nothing - I don't want to do it anymore'" (participant 7, nurse)

For OD novices, the introduction of this approach means being diverted from previously accustomed practices, like a one-to-one and solution-oriented approach. Working in treatment tandems also initially means additional work, raising questions of its benefits for some of them:

> "If you already have this attitude: "I don't have the solution", then it's not difficult to accept OD as a treatment form. Yet, for new colleagues, or if you come from a completely different conceptual background, then this may be difficult and a huge challenge." (participant 2, social worker)

> "Some staff members simply don't have the mindset to work according to these principles and find […] working alone better." (participant 13, social worker)

> "[…] they often find it too complicated to work in a tandem. […] asking the question: first of all, it requires a lot of time and what is the benefit?" (participant 1, psychologist)

Moreover, the shift to a dialogical way of dealing with different opinions and decisions may challenge previous, long-existing attitudes and behaviors. For example, the change of attitude from "talking about" to "talking with" was reported to cause great difficulties for many colleagues:

> "The temptation to return to old behavior patterns and follow an idea in your own head and to pursue that, instead of asking in a more open way, is sometimes difficult." (participant 13, social worker)

> "[…] due to reasons of time and probably also habit, I exchange information with the physician in charge far too often, without having the patient next to me." (participant 6, psychiatrist)

Going into more depth, handling of responsibility was perceived to be a challenge. On the one hand, it is difficult for many staff members to leave the responsibility for some decisions up to the network. On the other hand, the OD approach requires taking on more responsibility than was previously the case or even desired:

> "[…] when do we want to meet again next time? And when the patient answered, "in about three months or so", this seriously perturbed certain staff members who had great difficulty to accept not having contact for so long, and they first had to develop trust in the patient's resources." (participant 7, nurse)

> "And then there are people who feel more secure in their work in an inpatient context, because there are still colleagues to back them up, because they know they can hand over [the responsibility] and there is someone there to take it on." (participant 5, psychologist)

In extreme cases, these reservations played out as quite frankly expressed utterances of professional competition among colleagues from different professions or working for other service providers:

> "We had extreme problems at the beginning, there was really a lot of competition. Maybe because many doctors are used to being the practitioner and deciding about the treatment of the person of concern. That was really difficult at the beginning. There were doctors who said that if the patient let us accompany him, then they would stop treating him or her as a patient." (participant 2, social worker)

> "Resentment always, definitely. Most of all, by the way, with the medical profession, when you suddenly start wanting to have your say, so to speak." (participant 12, nurse)

> "Others have said, "We've always kind of done it this way. We don't need to deal with that." Or some have said: "We can't do that"."

Given these reservations, it is interesting to note that some of the interviewees found that rolling out OD in too short of a timeframe or with an overly radical desire for change represented additional obstacles promoting reservations from the outside:

> "At the beginning, I thought: we'll change to network meetings and not allow for any other forms of treatment anymore. That is, of course, nonsense. That can lead to people saying at some point: "We're not going to do anything anymore. Because the goal is too big. [...] you can also only start with single aspects"." (participant 3, social worker)

> "If you didn't call it Open Dialogue all the time, if you didn't sell it as the miracle concept from Finland, so to say, it would not scare people off so much [...]" (participant 16, psychologist)

Finally, it appeared in various interviews that a high level of individual commitment is required for successful OD implementation. This factor, in addition to the many obstacles described above led to frustration among some participants:

> "But this attitude is just not there yet. It's hard, you have to repeat it again and again and bring it in. It gets tiring over time if it always comes from me and there is little initiative from the others to educate themselves and try something out." (participant 11, psychiatrist)

4. Discussion

This article is the first to examine the spread and extent of OD implementation in Germany, together with the challenges and obstacles involved. Overall, the results of the survey demonstrated that a large number of facilities within various care contexts have implemented certain elements of OD. At the same time, the full set of OD principles was not simple to implement, which especially applies to the principles "immediate help in case of crisis" and "network perspective," which are currently only implemented on a regular basis by a few teams in Germany. Instead, mobile, flexible, and continuous support is implemented more consistently over time, as shown by the survey results, whereas the expert interviews demonstrated challenges in this regard as well.

Overall, the grade of implementation of OD structural principles was far lower than implementation of therapeutic principles. Presumably, this was mainly due to contextual contingencies, as expert interviews revealed that the teams investigated did their best to implement the OD principles as fully as possible under the conditions of their respective service structure and the German health care system. These efforts resulted in the achievement that, in international comparison,

Germany has the highest number of teams practicing OD to be found, as described in the global HOPEnDIALOGUE survey (Pocobello et al., 2022). On the other hand, the mental health structures in which the German OD-teams operate are significantly more stand-alone services than the OD-teams of other countries and report significantly less often to provide the OD principles: "Immediate help," "Social Network," Tolerate Uncertainty" and "Dialogue" (*ibid*). Thus, the high number of providing services must be treated with caution, as discussed below.

4.1. Contextualization of findings in relation to the German mental health care system

Of all participating teams, 42.1% do not offer network meetings on a regular basis for every client and only about 50% offer not more than two network meetings in total for every client. This situation is even more regrettable as network meetings are the central instrument of the OD approach. Likewise, immediate help with a network meeting within 24 h appears to be equally important to achieve desired OD outcomes. Therefore, the overall lack of implementation of this OD principle in Germany for 71.1% of the facilities surveyed may be considered rather problematic.

At the same time, there was a very simple explanation for these results, given the structural contexts of most of the participating services: Only 37% were open 24 h a day and 58% were outpatient services - which in Germany are usually not responsible for crisis care. In more detail, the contract terms of the integrated care services according to §140a (see above) required that clients were first contacted by their health insurances and had to enroll themselves after a further clarification process. This enrollment process was clearly too long for situations, in which immediate help to people in crises was needed. Thus, the included clients usually were not in a crisis state at the beginning of OD support. To give another example, practicing OD in the context of residential care usually meant that therapeutic relationships had been existing for longer times, sometimes years, so that the search for facilitators still unknown to the network often took some time, which is usually not available in the case of an acute crisis. In these cases, further, a social network first had to be activated, which again took time, before a network meeting could take place.

On the other hand, it should not be underestimated that a large part of the teams attempted to provide a needs-oriented and flexible support. The majority stated that the content (100%) and location (84.2%) of network meetings as well as the type (92.1%) and extent (78.9%) of further interventions were aligned as closely as possible to the needs of the clients. Conversely, in our view, this finding also confirms the structural dependence of the implementation possibilities of OD in Germany: Since these elements can be more easily adapted to existing structures and concepts of the German mental health care system, flexibility and mobility were usually indicated to be part of the routine care of the participating centers.

Altogether, the fragmented und institutionalized conditions of the German health care system indeed seem to hinder a comprehensive implementation of the OD principles. Accordingly, as mentioned before, the extent of implementation of OD in different countries and contexts is highly dependent, among other things, on the health care system (Buus et al., 2021). In its original development, the full implementation of the OD approach requires a distinct set of structural changes over several years (Haarakangas et al., 2007). In contrast, in our study, the average time between the first preparatory measure and the provision of the first network meeting was 1 year. And often, the implementation was not supported by the entire institution or even the leadership, as was clearly evident in the interviews. Thus, without a sufficient structural basis, a high number of OD teams in Germany must be presumed to depend largely on individual commitment, which was also addressed in some of the interviews. Such a bottom-up implementation of OD may lead to gradual adaptation of clinical practice but cannot provide a sufficient basis for a full change of existing structures and practices, as discussed earlier (Buus et al., 2021). Thus, it is understandable that the need for top-down implementation was emphasized in some interviews.

4.1.1 Legal and financial constraints

Regarding the legal conditions, half of the German OD teams were providing services under cross-sectoral model contracts according to §64b or §140a treatment conditions at the time of the survey. The results also revealed that the majority of OD implementation processes were preceded by introduction of one of these funding conditions in almost half of the survey cases, either triggering it or making it possible in the first place. Moreover, a detailed analysis demonstrated that the item "more than three network meetings per client" was shown to be significantly associated only to those institutions using cross-sectoral model funding, indicating a greater scope for a need-adapted support within these contracts. Thus, as expected, cross-sectoral model conditions do seem to have opened possibilities for implementing OD and a more flexible form of care. At the same time, as described before, those contracts include restrictions in terms of accessibility and duration available for the treatments offered and thus are not suited to secure stable and continuous treatment, as recurrently emphasized in the expert interviews of our study.

As a particularly dramatic example, an impressive network of OD services had been built up in Berlin and elsewhere (Mueller-Stierlin et al., 2017), in which multi-disciplinary teams offered crisis and assertive forms of home treatment to prevent hospitalizations on the basis of an integrated care contract (according to §140a SGB V). Yet the contract was signed only by one large and some singular regional insurance companies, denying access to patients of the roughly 140 other insurance companies. Furthermore, in 2021, most of the

contracts were canceled, after years of gradual cutbacks with the result that the providers participating were forced to stop their OD services, after having acquired valuable (and expensive) expertise for years and mostly without being able to offer adequate alternatives to their clients. Thus, OD projects under cross-sectoral model conditions (§64b and §140a, SGB V) usually have a limited funding duration even if their results would often justify a transfer to standard care.

In our view, the wider context for this situation is the increasing economization of the (German) (mental) health care system, leading to a significant cutback of jobs, as well as the use of selective contracts covering expenses only for brief treatment periods or short-term interventions, as mentioned frequently in most of the interviews. Fittingly, inadequate funding structures and lack of resources are a common obstacle to the adequate implementation of OD approaches (Buus et al., 2021), which were also mentioned several times in our expert interviews. This trend seems to be spreading ever further in Germany, pointing to the lack of the political will to change it – or as one of our interview partners framed it: "OD must be politically desired. But this kind of work has no lobbies behind it. They [cannot] make any profit out of it. [...] Because our capitalist system has no interest in it." (participant 1, psychologist). Inversely, health economic analyzes indicate that most of Germany's financial resources are spent for inpatient treatment and outpatient drug prescriptions while only a small part of the mental health care budget is spent on outpatient services (Heider et al., 2009; Salize et al., 2009). Thus, it could be expected that the German mental healthcare system could be significantly improved by shifting resources from inpatient to outpatient care. Yet, legal regulations applicable to health care financing, as well as organizational issues, represent major barriers against this shift from inpatient to outpatient as well as from medical to psychosocial services (Bauer et al., 2016).

4.2. Is it structure – Or is it attitude?

At the same time, both the survey and interview data made clear that certain OD elements were implemented despite the limiting structural conditions under different funding contracts, demonstrating that an extensive restructuring of mental health care conditions may not be a *sine qua non* for the implementation of *all* principles. Conversely, even if a team was funded according to the more flexible cross-sectoral model contracts, this did not necessarily guarantee that a great extent of implementation of (all) OD principles had been achieved, indicating that there must be other reasons than the health care context to explain for this shortcoming.

The reasons for this finding relate to obstacles on different levels. For example, expert interviews revealed various obstacles both on a meso- and micro-level, such as a lack of support from the senior or executive management. Thus, as shown in results from other studies, it may be argued that the implementation of OD inevitably leads to challenges and can only succeed through an adaptive and committed leadership (Lennon et al., 2022) and organizational change management processes (Buus et al., 2021).

On the other hand, in terms of implementation, not only the structural principles' implementation seemed to depend on an upstream change of the health care context, but also certain therapeutic principles may depend on structural conditions for their (full) implementation. For instance, "asking open questions" or "tolerance of uncertainty" (instead of seeking quick solutions) may require more time, which in the end means resources. This may explain why only about two-thirds of the institutions participating in the survey try to prevent early decisions or tend to discuss them openly during network meetings.

Other therapeutic principles seem to be less structurally dependent, but they primarily require a change of attitude to be implemented: for example, discussions about the clients and networks in their presence were reported by only 47.4% of the participants to be applied at their institution regularly. Supported by the interview data and other studies (Dawson et al., 2019; Tribe et al., 2019), this leads to the hypothesis that in addition to the lack of adequate structural conditions, barriers for implementation can also be found in the attitudes of individual staff members or an institutional culture as a whole, caused by personal doubts or resistances, when an OD principle challenges previous treatment routines or approaches.

4.3. Why do we need fidelity?

The significant impact of attitude and the required change of culture mentioned leads to the question of what actually constitutes the OD approach and at what point an implementation can no longer qualify as "Open Dialogue." It has been argued that clear, transparent, and accepted criteria of fidelity are important to ensure and monitor sufficient implementation (Waters et al., 2021). If and how the OD approach is implemented or not, should not depend on personal decisions or tastes but requires clarity, consistency, and careful implementation of principles to ensure good quality care for clients and their networks, as well as to facilitate further research on the outcomes of OD.

To pursue this goal, a set of clear and communicable criteria is needed to analyze the extent to which this approach has been delivered and the quality level (Waters et al., 2021). Such a set is also needed for various reasons: first, to allow for communication on this topic among members of the OD community and externally, second to facilitate the transferability and translation of this approach in various contexts, and third to reduce harmful processes with definitional power regarding the "real nature of OD" (Von Peter et al., 2022).

At the same time, finding adequate fidelity criteria for the OD approach looks like quite a complex task. The inbuilt principles of openness, need-adaption and flexibility make

distinct definitions challenging (Waters et al., 2021) without devaluing these core elements. Thus, there could be a risk of ruining the very foundations of the approach if fidelity criteria are too strict or normative, thereby potentially obstructing helpful variances of the OD approach for users and caregivers. It is useful to present one example of these variances. As a creative response to the structural constraints limiting full implementation of the OD approach in Germany, a variety of modified versions have been developed. For example, the so-called treatment conference has been developed on an acute care unit to replace the traditional, rather top-down senior physician's rounds in such a way that allowed for a connection and transition to the newly introduced dialogical network meetings (Aderhold et al., 2010). These conferences are applied in some hospital departments today allowing for more dialogue and reflections among the team in the presence of the patient to provide for feedback to the patients of concern and request their response with or without additional practice of network meetings which is justified with lack of time.

These and other, certainly worldwide existing variants of the OD approach would not qualify as OD or would likely not have been developed in the first place, if too narrow of a focus on a definite set of fidelity criteria takes precedence over the nature or quality of the OD implementation process. Thus, fidelity criteria should make it possible to talk more clearly about the framework conditions, processes, and extent of implementation, but should not restrict the range of possible OD practices.

Even more importantly, the (non-)implementation of any of the OD practices or respect of fidelity criteria cannot measure users' and carers' experiences of an OD service. Given the current lack of adequate studies that confirm the causalities between OD fidelity and outcomes, we must be cautious about drawing overly narrow conclusions on this issue. Hopefully, the ODDESSI trial will shed some light on this question (Pilling et al., 2022), but even if it does, this will not make it possible to define these associations authoritatively in a particular clinical situation. In this respect, a plurality of "evidence" could be useful in our opinion, challenging the evidence-based medicine hierarchy of knowledge and bringing to the fore the highly important narrative evidence that has been produced since the beginning of OD development, largely contributing to its current shape and effectiveness.

It remains to be seen if better terminology to differentiate and communicate the differences in implementation and variances of the OD approach is needed for these purposes. While collaborating on this publication, we experimented with various terms, such as "OD-oriented" or "-inspired" services, or "dialogical networking," also inspired by similar discussions in relation to Soteria services that use a corresponding fidelity scale to clearly differentiate grades of implementation. However, we decided not to use these terms in the end here, as each of them would require a more extensive discussion, with other authors in addition to our research team, to determine what counts as "full" or "minor" OD implementation.

4.4. Limitations

The limitations of the survey relate to the questions used, as they were not based on a validated questionnaire, thus limiting the accuracy of the results. It should also be noted that the survey data collected were exclusively self-reported, which also affects the validity of the results. Moreover, the responses for each team were always gathered by one person and it was not possible to check whether the responses were coordinated with all of their team members. In this respect, the survey results should be understood as an approximation and not as a precise picture of the OD care landscape in Germany. On the other hand, a distortion of the data in the sense of social desirability would, in our view, be expected above all in the levels of implementation of the fidelity criteria. It was precisely here that the results were particularly sobering.

The limitations of our qualitative study first came from the limited number of expert interviews. As a result, this aspect of the study suffered from the shortcoming that it did not involve one representative of each participating institution of the survey study. Due to the restriction of resources, it was not possible to include a larger number of interview partners. However, during data analysis, we recognized a sufficient saturation of the material, with similar themes repeating again and again over the course of all interviews, making the approximations based on comprehensive results. This article focuses on the topic of implementation challenges and obstacles, rather than a discussion of possible solutions for them, including those mentioned in interviews. The goal of this sub-study, however, was to understand these challenges in depth, which might not have been possible if also discussing the possible ways out.

5. Conclusion

Despite various structural and other barriers, a large number of teams, working in the field of psychosocial and psychiatric care in Germany, apply OD related elements in their treatment approach. As shown, OD is not implemented to its full extent in each of the institutions surveyed. This has led to the suggestion to start a broad discussion among OD researchers, practitioners and clients to develop a more refined terminology to define and communicate variants of OD implementation, involving terms such as "OD-oriented" or "OD-inspired" services. This article has made it clear that more extensive implementation of the OD approach in Germany, as maybe elsewhere, is prevented mainly by the conditions of the health care system. This is even more worrisome, as community-based, flexible, and needs-oriented forms of psychosocial care are strongly recommended by many guidelines today, regardless of the OD approach (Gühne et al., 2018; WHO, 2021).

During the production of this article, the authors, as OD trainers and practitioners who are attached to this approach, frequently oscillated between appreciation for what the German

teams had made possible despite the prevailing adverse health care conditions and disillusionment seeing how in certain cases, OD principles were implemented in a rudimentary way. Yet, these feelings of ambivalence may also apply to other health care sectors too, the implementation of the OD approach usually being dependent on significant adaptations of the health care context (Buus et al., 2021). Finally, this article was not designed to provide information on the outcomes of the services involved on the experiences of the users and caregivers benefiting from OD. These additional aspects must be covered *via* a subsequent study to record and analyze the effectiveness of OD services in Germany.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Author contributions

KH co-developed the expert interview questionnaire, revised, and adapted the code tree, re-analyzed the survey data and wrote the article. MK developed the German adaptation of the cross-sectional survey, conducted the examination, and first analysis and co-developed the expert interview questionnaire. MB and HT developed the expert interview questionnaire, conducted, and evaluate the expert interviews. RP developed the questionnaire of the cross-sectional survey, helped with the analysis. YI helped with adaption, conduction, and analysis of the German survey. VA co-developed the expert interview questionnaire and the German adaption of the survey, helped with the recruitment for both survey and expert interviews, discussed the overall results. SP developed the expert interview questionnaire, evaluate the expert interviews, developed the German adaptation of the survey, discussed the overall results, and co-produced the article. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Anticipation dialogs in Vermont's system of mental healthcare: Sustaining the growth of a dialogic practice culture

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Open dialog is both a therapeutic approach and a way of organizing the system of mental healthcare that has been evolving in Finland since the 1980s. In Vermont, over the last decade, there has been an organic statewide effort to begin to integrate dialogic principles into the public system of mental healthcare. Because of the organic nature of these initiatives, there have not been coordinated systemic changes to support dialogic practices. To learn what visions participants in dialogically informed practice contexts have for the future as well as what structural innovations would support these visions anticipation dialogs were offered at three dialogically informed community mental health centers and one public psychiatric. The anticipation dialog was developed in Finland during the late 1980s to aid stuck professional and social networks in finding ways to move forward looking back from an imagined positive future. Twenty-seven multidisciplinary staff members and one service recipient participated in the dialogs. The authors conducted a multi-step process of thematic discourse analysis of all 4 anticipation dialogs. Findings underscore dilemmas entailed in growing a dialogic practice system, including the toll systemic uncertainty takes on workers in the system and the simultaneous pull to offer some amount of open-endedness to the system change process in the spirit of inclusiveness, mutual trust, democracy, and reducing hierarchy. Other key findings influencing sustainability of dialogic practices in community mental health include integrating dialogic work into roles rather than adding them to existing responsibilities. Our experiences indicate that anticipation dialogs may be a way of conducting systemic research that contributes to the forward momentum of system innovation. Offering a greater length of time for organizational anticipation dialogs would be valuable, as would centering the voices of clients and their networks.

KEYWORDS

open dialog, anticipation dialogs, dialogic practice implementation, community mental health, inpatient, person centered rounds, collaborative network approach, dialogic systems change

1. Introduction

Open dialog is both a therapeutic approach and a way of organizing the system of care (Seikkula and Olson, 2003, p. 1). As such, successful integration of these practices into services must reckon with the larger systemic context. Any attempt at systems integration of dialogic

principles also begs the question of exactly how this can be done *dialogically* as an organic process that staff gravitate toward on their own volition, described by Smith (2022, p. 175) as "collaborative practice development." To proceed "organically" respects the subjectivity of workers in the system, does not run the risk of workers participating in a dialogic process who are not themselves open to such a process (Parachute NYC, 2015, p. 42, 72) and potentially ensuing negative consequences for clients and their social networks. However, an organic approach that develops in a nonlinear rhizome-like manner (Florence et al., 2020, p. 10), can make it difficult to develop the infrastructure and systems necessary to foster dialogic responses.

It can be argued, that because of the small population and highly democratic culture of Vermont, the social services system is well positioned to support innovation and dialogically informed practice. In spite of this, there are many potential barriers to integration of the principles of open dialog including but not limited to Federal and state funding structures and requirements. This paper briefly describes how inpatient and outpatient staff at four sites that have been training in and practicing dialogic approaches hope to change their systems of care to better align with the seven principles of open dialog. Staff who train in open dialog are faced with the challenge of integrating dialogic practices into varying contexts that are not necessarily set up to support these practices. This "disruptive innovation" (Parachute NYC, 2015, p. 28) can at times be experienced as internal dissonance between the adhering to the principles of dialogic practice and attempting to do so in trainees' actual work contexts. This dissonance can have a range of impacts on staff morale and the sustainability of dialogic practices in Vermont. We invited staff to share their visions through anticipation dialogs in which actors in stuck systems are able to envision a way forward by looking back from an imagined positive future (Arnkil T., 2019, p. 38). Here, we analyze participants' visions for change as well as their perceived barriers to systemic integration of dialogic principles in Vermont's system of care. We go on to offer reflections that may be worth considering for others who hope to integrate dialogic principles into community mental health and hospital settings.

At the time of initiating this project, the authors, social workers at the Counseling Service of Addison County, were concerned that the momentum we had worked hard to achieve in developing dialogic responses to mental health in the state of Vermont were being undermined by the level of crisis in our system of care and our larger society. This crisis was brought about by the pandemic, increasing social and political polarization and a national shortage of human service workers. We were also informed by the idea that times of crises hold within them the possibility for profound and worthwhile change. We believed that inviting staff to participate in anticipation dialogs would offer a way to extricate themselves from this confounding moment and look back on it from an imagined positive future. We hoped that this would offer participants a sense of reprieve, joy, and connection in the moment, as well as some nourishment to help them to continue on this dialogic journey. As Seikkula et al. (2003, p. 197) write, "to enhance commitment, it is necessary to encourage credible hope." We also hoped that it would increase a sense of direction and accountability. In addition, we hoped we might offer any learnings from this process to the Vermont Department of Mental Health, so that in better understanding our visions and the associated barriers, they might have a clearer sense of how to support our efforts.

1.1. Vermont practice context

Based on the estimation of the 2018 US Census, Vermont's population was 645,570,[1] the least populous state in the nation and is known as a "human-scale democracy."[2] Vermont's 14 counties are served by 10 designated mental health agencies (DAs) and two specialized service agencies (SSA's). The DAs have autonomy to design their services so long as they conform to standards set by public and private health insurance, include a 24-h mental health crisis service, community psychiatric support for people who have had frequent and/or lengthy psychiatric hospitalizations, developmental services as well as community and school-based support for youth and families. These agencies are overseen by the Vermont Department of Mental Health. The Department of Mental Health oversees one public Vermont Psychiatric Care Hospital and has administrative ties to five other psychiatric inpatient units within the state.[3]

In 2011, the crisis of Tropical Storm Irene's flooding of Vermont's statewide psychiatric hospital gave rise to the state's willingness to redirect funds toward enhanced community-based responses to mental health crises with the aim of hospital diversion (Smith, 2022, p. 171). Some Vermont-based psychiatric survivors were advocates of the state pursuing open dialog as it prioritizes the agency of the person at the center of concern, increases choice with regard to mental health treatment, and mitigates against coercion (Anonymous, 2019). Some administrators and service providers within the designated mental health agencies (DA's) and Vermont Department of Mental Health were attracted by the outcomes reported by Western Lapland. According to a study conducted in 2011, using the open dialog approach, as of 2005 new cases of schizophrenia in Western Lapland decreased from 35 cases per 100,000 individuals to two cases per 100,000 individuals (Seikkula et al., 2012). In addition, the DUP (the duration of the untreated period) had declined from 2 to 3 years in Finland's traditional psychiatric system to 3 weeks in Western Lapland; and 84% of individuals served had returned to full employment. Furthermore, this study had replicated the following results of the period from 1992 to 1997 in which only 35% were treated with neuroleptics, 81% experienced complete remission of symptoms, and 81% had achieved full employment (Seikkula, 2002). A follow-up study documented greatly reduced hospitalizations, use of neuroleptics, and utilization of disability benefits (Seikkula and Arnkil, 2006). In a 19-year follow-up study, Bergström et al. (2018) note that indices of hospital days, use of neuroleptics, and reliance on disability benefits continued to remain lower with people who were responded by practitioners of open dialog. These outcomes were resonant with those of the Vermont Longitudinal Project, the longest study of deinstitutionalization and the second longest study of people diagnosed with schizophrenia which found: 62–68% of "people who were expected to grow old and die at Vermont State Hospital reclaimed their lives," 81% were able to care for themselves (Harding, 2014).

1 United States Census Bureau (2018). *QuickFacts: Vermont*. [online] Census Bureau QuickFacts. Available at: https://www.census.gov/quickfacts/VT.

2 Bartlett, E. (2017). "Human-Scale Democracy" Credited for Vermont's Culture. U.S. News & World Report. [Online]. Available at: "Human-Scale Democracy" Credited for Vermont's Culture (Accessed September, 2022).

3 mentalhealth.vermont.gov. (n.d.). Designated Hospitals | Department of Mental Health. [online] Available at: https://mentalhealth.vermont.gov/individuals-and-families/designated-hospitals (Accessed September 25, 2022).

Through the advocacy efforts of Vermont psychiatric survivors and leaders within several of the DAs, beginning in 2012, funding from the Vermont Department of Mental Health (DMH) was secured to support training in dialogic practice open to workers in the Vermont system of care offered by the Institute for Dialogic Practice. Leaders at the Howard Center, United Counseling Service, Vermont Psychiatric Care Hospital, the Counseling Service of Addison County, and DMH went on to create a statewide training program that would be viable within the context of community mental health with the support of trainers from Tornio, Finland, Norway, Berlin, as well as from Parachute New York and Advocates in Massachusetts. The training was intentionally multidisciplinary; including psychiatrists, case managers, peer support workers, social workers, residential staff, psychologists, nurses, mental health technicians, and mental health counselors working primarily in adult mental health, but in youth and family and developmental services as well. These staffs served both people experiencing first time crises and people who have had long-term involvement with the public psychiatric system. From the beginning, the intention was to inquire into offering dialogic responses to people experiencing a wide range of difficult situations, not solely limited to what has come to be called "early episode psychosis."

In Vermont community mental health, open dialog-informed practice is referred to as the Collaborative Network Approach (CNA), to underscore that we are not working within a treatment system that is designed to embody the principles of open dialog. While profoundly inspired by the seven principles of open dialog (immediate help, social network perspective, flexibility, responsibility, psychological continuity, tolerating uncertainty, and dialogism), we are operating in different contexts, with differing opportunities and constraints, and must develop approaches that respond to the needs of the particular contexts in which we practice. Although the Vermont Department of Mental Health and the leadership of early adapter mental health agencies and hospitals have been supportive of CNA training and practice, there has not been a comprehensive, systemic commitment to the principles of open dialog or remaking our system of care to be in accordance with these principles.

Some of the participating agencies have also offered in-house training conducted by graduates of the statewide training. At the time of writing this article, we have held four 15-day intensive level 1 statewide trainings and four 10-day level 2 statewide trainings. A total nine agencies have participated including two hospitals and seven community mental health agencies, some of which include residential programs. Of these, three outpatient community mental health centers, Howard Center (HC), United Counseling Services (UCS), Counseling Service of Addison County (CSAC), and one involuntary inpatient facility, Vermont Psychiatric Care Hospital (VPCH), were the initial organizations that came together to plan the statewide training, and who likewise participated in this study. From the outset of this collaboration, each were at different stages of beginning to work with dialogic principles in their own contexts. As we have continued to collaborate on statewide dialogic initiatives, we have each evolved these practices differently in our specific contexts, encountering varied possibilities and barriers.

2. Research methods

At the time of this study, the authors were enrolled in *Dialogical approaches in couple and family therapy. Psychotherapy trainers training* organized by Dialogic Partners and the University of Jyväskylä. Included in this program was a 2-day seminar with Tom Arnkil, lead innovator of Anticipation Dialogs. Tom Arnkil also remained available to us for several email, zoom and in-person consultations as questions about methodology arose. We began with the following research questions: What were the visions held by staff at participating organizations with regard to the integration of dialogic practices in our system of care? What were the perceived barriers to realizing this vision? What steps could they imagine taking to reduce these barriers? What actions could Vermont DMH take to further support the CNA initiative throughout the state?

It was important to us that these questions be explored dialogically so that at a time when our professional relational world was under duress, the research process would utilize practices that strengthen networks through listening and deepening understanding (Seikkula et al., 2003). Dialogic approaches to participatory research have been conducted to useful effect elsewhere both within and outside of the social welfare system (Laarni and Aaltonen, 2014; Soggiu et al., 2021). This approach to research actualizes the concept that networks have no centers because each person is the center of their own network (Seikkula et al., 2003). It builds on the:

> "incomplete nature of knowledge and the recognition that different participants use different sorts of knowledge. Thus new understanding could be created by including theoretical knowledge and lived experiences" (p. 228).

To be consistent with the practice of open dialog guided as it is by the co-creation of knowledge, rather than a top-down approach to the production and assertion of knowledge, we chose the framework of anticipation dialogs as a way of gathering knowledge from staff positioned in multiple vantage points within Vermont's mental health treatment systems.

2.1. Brief description of the eight principles of anticipation dialogs

Anticipation dialogs are one-time consults offered to clarify complex situations otherwise known as "multi-agency muddles" (Arnkil T. E., 2019) and to collaboratively find a way forward with stakeholders and colleagues. Tom Arnkil and his workgroup began to develop this practice at the Finnish Institute for Health and Welfare in the late 1980s. Continued research into and development of anticipation dialogs were organized by Finland's National Research and Development Center for Welfare and Health along with several Finnish cities through the 1990s (Seikkula et al., 2003). These initiatives aimed to develop resource-centered methods, a network-oriented work approach, and service structures that transcend sector boundaries to prevent the iatrogenic fragmentation that occurs when a family or child is at the nexus of many specialized professional providers and systems. Akin to open dialog, this innovation privileges respectful and valuing ways of working with clients and their natural supports, and attends to the resilience of clients' relational and psychological resources (Seikkula et al., 2003).

Anticipation dialogs exist in an imagined positive future and are underpinned by the eight principles highlighted in bold that follow (Seikkula et al., 2003). Two workers from outside the client/provider

network offer facilitation to mitigate against the ways that professional hierarchies within agencies and across sectors can act to silence voices, and" to curb cycles of domination and blame" (p.197). In an organizational anticipation dialog, time would be taken to note positions of influence among participants, and to invite those with the least influence to be the first to speak. Beginning with the clients who answer one by one, the facilitators invite those present to imagine a future (the timing of which is agreed on collaboratively at the outset of the meeting) in which the current troubles have been resolved. A future perspective is the basis for coordination, as it offers participants freedom from the stuckness of the moment and makes all equals in the face of no one participant being able to "know the future" and making space for all participants to become curious about one another's anticipations (p.198).

They ask:

1. *"A year has passed, things are quite well. How are they for you? What are you especially happy about?"*
2. *What did you do to bring about these positive changes? Who helped you and how?*
3. *What made you worried a "year ago" and what lessened your worries?* (Arnkil T., 2019, p. 38).

Each person's subjectivity is highlighted as they are asked to share their view, aiding in the "transition from objective problems to subjective concerns" (Seikkula et al., 2003, p.198). While each family member is sharing, other family members and providers are listening without interrupting and without the goal of responding directly. In this way, "voices echo in each other" and polyphony is achieved (Arnkil T. E., 2019, p. 593). Movement forward is through each participant being informed by increased understanding of the other made possible through dialogism, not in an attempt to impose one view of the problem on other, and to attempt to change or control them through hierarchical means. This requires, tolerance of uncertainty, as networks are too complex to be controlled, however, increased understanding of one another is possible.

Once it is time for the professionals to share (or in the case of organizational anticipation dialogs, for those of more influence to share), they are in a position of being informed by what they have heard from those who have already spoken, and how this has acted in and on them. To foreground the reciprocal character of professional work, the facilitators invite them to speak subjectively, from the vantage point of their worries, rather than from a monologic vantage point of naming the problem of others in objective terms. The anticipation dialog itself is a series of experiments in thought and action that honors the experimental rather than certain nature of all human activity, helping to level the playing field in the dialog and open space for new directions to emerge (Seikkula et al., 2003).

Once all dialog participants have shared their responses to the three categories of questions written above, the facilitators invite everyone back to the present moment and use the they have taken from the "recalled future" to agree together on who will do what with whom next. While the plan of action is important, its value is based on what occurred during the process of generating it: experiences of listening and being heard engendering all participants to move forward in a relational context of increased understanding and respect for each other's particular vantage points (Arnkil T., 2019).

2.2. Adaptation of anticipation dialogs in this study

We conducted four anticipation dialogs as case studies with four early adapter agencies: Vermont Psychiatric Care Hospital (VPCH), Howard Center (HC), Counseling Service of Addison County (CSAC), and United Counseling Service of Bennington County (UCS). Leaders in CNA at each organization were sent an email outlining the purpose and intention of our research, which was described as: offering an opportunity to share visions of how they would like to see the Collaborative Network Approach (CNA) and/or dialogically informed practices to have taken root in their work context within the next several years as well as with the hopes of keeping CNA's momentum going, identifying what concrete steps agencies and the state could take to support these initiatives, and to be supported by one another's visioning processes. We requested that 3–7 staff from each respective agency participate, and that staff be included from different hierarchical levels of influence and varied professional roles. We offered to meet *via* zoom or in person. Two of the three authors of this article were to facilitate the dialogs at UCS, VPCH, and HC. Outside facilitators were engaged to facilitate the anticipation dialog at CSAC. Outside facilitators were engaged to so that authors: (1) might have a firsthand experience of "being in the dialogue" as a way to help us reflect on the process of utilizing anticipation dialogs in this way; (2) could contribute to the development of CSAC's vision; and (3) to open up more space for CSAC dialog respondents to speak freely.

The first anticipation dialog took place in person at the Vermont Psychiatric Care Hospital on October 20, 2021 and included five participants from the sectors of nursing, psychiatry, psychology, management, and social work. Our second anticipation dialog took place *via* zoom on October 22, 2021 with the United Counseling Service of Bennington County and included four participants occupying different roles in the agency including management, direct service, and clinical staff. The third anticipation dialog we conducted was in person with the Howard Center on November 8, 2021 and included three participants who occupied different roles within psychiatry, management, and clinical work. Our final anticipation dialog took place at CSAC on April 4th and included 16 participants in total, eight in an inner circle and eight in an outer circle. The inner circle consisted of participants spanning clients, peers, clinical staff, psychiatry, and management. This format was slightly different in that the outer circle participants were given an opportunity to reflect from a future position on what they had heard the inner circle participants express on two separate occasions. Unlike dialogic meetings, these reflections were not shared with an opportunity for the inner circle to respond to them, rather they were shared within time constraints with the intention of the inner circle hearing them and then responding to different prompts posed by the facilitators.

As suggested by Arnkil T. (2019), to begin the anticipation dialogs, we collectively imagined the time frame of the dialog to be in the future. This time frame was set by collaboratively asking the participants how far in the future a positive reality in the implementation of dialogically informed practices would be possible. The anticipation dialog questions were then asked in a sequential order, asking one participant each question at a time. Our intention was to begin our round of questions with the person with the least

hierarchical influence answering the first question first. The first question asked was, "What are you particularly excited about in relation to dialogically informed practices in the year 'x' and what contributed to these changes being possible?" Following the individual responses to this particular question, we asked each participant to elaborate on the actions they took to contribute to these changes being possible, who helped and to share any steps they took that they were secretly proud of. We asked the participants, one at a time, to give voice to their unique perspectives in answering these questions, aiming to end this round of questioning with the person with the most hierarchical influence answering last.

We then asked the next anticipatory dialog question which was, "What were you worried about 'x' years ago and what helped lessen your worries?" This question was intended to begin with having the person with the most influence within the workplace hierarchy answer first. Following the individual responses to this question, we asked each respondent how they contributed to reducing the worry including what actions they took and who helped them. In the same manner as the first question, we asked each participant to respond one at a time and aimed to end with the person with the least influence in the hierarchy answering last.

During the responses to the above mentioned questions, notes were shared with the research participants to ensure that we were accurately capturing their utterances. We concluded our anticipation dialog by reviewing the action steps which were mentioned by each participant, clearly outlining who was going to take responsibility, and clarifying an intended time frame as well as who supported each action taken. We also asked when they would meet to discuss these identified next steps. We then asked the research participants how this experience was for them.

We typed up the notes from the anticipation dialogs as well as the action plan and emailed these documents to all of the research participants. In the final portion of our analysis, the authors of this study wrote reflective narratives about our experiences of facilitating these dialogs and shared these with each other.

2.3. Anticipation dialog discourse analysis

To analyze the anticipation dialogs, the authors engaged in a multi-step process of thematic discourse analysis (Davies, 2008, p. 186–192). During each anticipation dialog, verbatim transcripts were taken and shared visibly with the participants in real time of their responses to the semi-structured interview questions. These questions aimed to illuminate participants' hopes, what made this hopeful future possible, their worries, what lessened their worries, and also the steps to be taken by whom and when. We member checked these transcripts by sending them to each participant after they were typed, requesting approval by each participant, and asking for any edits if what was typed did not match what they recall saying. It needs to be noted, not all participants gave feedback to these transcripts.

After soliciting feedback on the transcripts, the authors of this study engaged in a thematic discourse analysis. Salient themes from each anticipation dialog were analyzed and quantified. As much as possible, the data which resulted from the anticipation dialog interviews guided the analysis. No pre-existing theoretic model was used to analyze the data—our analytical process was informed by grounded theory (Glaser and Strauss, 1967). The themes which had the most resonance and frequency across participant organizations, as well as within each organization, became the findings that were generated from this research. This was achieved through an extensive process of reviewing all of the participants' transcribed utterances, highlighting patterns and then quantifying the frequency of shared themes used by different persons in their responses to the same questions.

The first step of this analytical process was to review the responses to the semi-structured interview questions and identify common themes, paying careful attention to the precise words used by participants and their unique meanings. Once these themes emerged, after reviewing all of the utterances and attending to the specific meaning expressed by each participant, we clustered the participants' responses into sub-themes. After all of the utterances had been reviewed, analyzed, and placed in a thematic category, we were able to quantify the frequency of each theme. This analytical process led us to our findings which will be discussed below.

2.4. Reflections on conducting anticipation dialogs in this study

Anticipation dialogs were organized during regular work hours, on-site at the workplace or in one case during work hours on zoom. The impingement of the workday on the dialogs was felt by participants at times needing to leave early or arrive late or step out for portions of the dialog itself. In one case, during breaks, staff refrained from conversation with one another and instead raced to attend to work responsibilities. Whereas in another workplace, staff took the break time to socialize with one another and the facilitators. Mood and the degree to which staff shortages and the pandemic felt oppressive varied from workplace to workplace. The norms of online meetings seemed to detract from the attentiveness of the listening process, as it was more permissible for folks to attend to other work responsibilities when they were not the one being interviewed, or just to turn off their cameras. This also interfered with being able to stick to the order of interviewing in the order of least to most influence as at times participants "popped off the zoom." In one workplace, it was the first time key staff had met one another in person, due to the pandemic. At times we felt that the anticipation dialog was adding to the worries of staff, putting pressure on them to talk about actions they would take, when they were already feeling so overburdened by the severe staff shortage. On one occasion, before the sequence of questioning began, an impromptu informal discussion took place in which hopes for person-centered-rounds were described by a participant who held a role of power within the organization. It is possible that this may have yielded influence, unintentionally, on what other participants then shared in the dialog. The authors take responsibility for this and recognize the importance of the structure of anticipation dialogs in opening the conversation by first interviewing the person who has a position with the least organizational influence. We noted that in one case, the presence of a director clearly articulating support for this way of working as well as identifying clear funding streams seemed to further invigorate the visioning process, and seemed to motivate other participants to be more involved to take action. Participants expressed gratitude for this process as well excitement for what was to come. In another case, several key leaders and decision-makers who had intended to

participate were unable to due to an emergency. This seemed to have negatively influenced the viability of the dialog and the mood. Compounded with recent staff departures, this group seemed to find it more difficult than the others to participate in the dialog from perspective of a positive imagined future. It is also possible that staff's protectiveness of each other may have inhibited what it felt possible to share. The stress and pressures expressed during the worries may have foreclosed on a sense of viability to build and enlist one another in a concrete plan. It also may be the case that if a whole day had been offered, a plan might have been arrived at that would have been better able to attend to those worries.

One dialog was conducted by facilitators from outside of Vermont—former community mental health workers themselves who were informed by dialogic practice and had been mentors in open dialog to Vermont practitioners. The dialog included a total of 16 staff with an inner circle of eight actively sharing their delights and worries and making the plan, and an outer circle of eight offered reflections to each other in dyads/triads, and then to the larger group. All but one member of the outer circle shared a reflection with the full group. Two of the researchers participated in the outer circle, and one participated in the inner circle. It was difficult to gauge how and in what ways to use our voices to influence both the content of the dialog and the process with regard to several facilitation decisions that the facilitators directed our way. In one anticipation dialog, two service users (a family member and a person at the center of concern) who have experienced dialogic meetings had planned to participate, one was not able to at the last moment, leaving one to hear the possibly overwhelming nature of staff worries. It would have been helpful to take more time to orient service recipients to the anticipation dialog format ahead of time to increase their sense of safety and clarity about the process.

In the workplace with the most people participating in the dialog, there was a lengthy discussion of in which order to respond and how to determine degrees of influence. This led to other portions of the dialog being more rushed. This took so much time that there was less time to develop the action plan at the end of the dialog and there was no opportunity to debrief. It is possible that when involving such a large group, it would be helpful to have a whole day—with lots of breaks built in (Arnkil, 2022)! And perhaps, as noted by Laarni and Aaltonen (2014, p. 326), in a workplace setting an "iterative series" of dialogs may be called for since "the future is difficult to anticipate, the cyclical paradigm can be used to foster and develop multiple perspectives of the future."

3. Results

Please see the tables listing the most saturated themes for each major line of inquiry of the dialog (Delights of working in 2024—Table 1, What made them possible—Table 2, Worries—Table 3, and What lessened worries—Table 4) following the discussion.

TABLE 1 What are you most delighted about in 2024? (Themes with the highest saturation): Out of a total of 49 themes, these 12 were the most highly saturated.

Frequency	Theme
27	Increased morale (satisfaction, inclusion of all, connectedness, trust, and at east)
25	CNA integrated into job descriptions (manageable workload)
23	Culture change
19	Dialogic system expansion (systems change)
14	Person centered care
13	CNA sustainability
13	Dialogic training/ supervision/ orientation
8	Prioritizing resources of natural supports
6	Increased access for CNA to clients and community
5	Peer support and human rights
5	Working in pairs
5	Inpatient/outpatient continuity

TABLE 2 What made changes possible? (Themes with highest saturation): Out of a total of 32 themes, these 11 were the most highly saturated.

Frequency	Theme
26	Training (inter-agency, intra-agency, and wider community)
13	Funding increases (explored and expanded)
13	Increased implementation
11	Support from key decision-makers/ leadership
11	Interested staff have more opportunities to participate
9	Cross silo communication/teamwork
8	Wellness as a collaborative project (staff and greater community)
5	Sustainability
4	5-year development plan
4	One-on-one staff conversations about change
4	Values shift for staff

4. Discussion

Here we will offer an analysis of the prevailing themes of the anticipation dialogs, offer reflections on the process of conducting the dialogs, note the limitations of this study and, lastly, share some thoughts about this study's implications for practice. The theme is followed by the number indicating the frequency with which the theme was mentioned by dialog participants.

TABLE 3 What were you worried about in 2022? (Themes with the highest saturation): Out of a total of 40 themes, these 12 were the most highly saturated.

Frequency	Theme
11	Low staff retention
9	Lack of support
9	Influences of other forces at play
8	Over-working and burnout
7	Staff not wanting change
6	Lack of funding
6	Tough times
4	Asking staff to do more
4	Inadequate political and economic power/state support
4	Not having capacity for handling demand for CNA
4	People would not show up
4	Priorities would shift to not be patient-centered

TABLE 4 What lessened your worries? (Themes with the highest saturation): Out of a total of 22 themes, these nine were the most highly saturated.

Frequency	Theme
10	Support from key decision-makers/ leadership for system change
9	Alignment of infrastructure and systems with dialogic practice
9	Integration of CNA into job descriptions/roles
7	Accessing new funding sources in the public and private sector
6	Having patience while staying engaged with this model (not letting perfect get in the way of the good and continuing to practice dialogically)
4	Having faith that those exposed to this model would find it meaningful and valuable
4	The spread of passion for this work (energy and revitalization)
4	Showing up for one another
4	Building capacity/sustainability

4.1. Analysis of results

4.1.1 Delights of working in 2024

Increased morale (27) was the most frequently discussed concept. Increased morale encompasses several unifying topics that include respect, trust, happiness, purpose, momentum as well as inclusion of all staff. This concept can be further understood by the themes that immediately follow such as manageable workload, culture change, and dialogic systems expansion (systems change). Seikkula and Olson (2003) have put forward the idea that open dialog is both a therapeutic approach and a way of organizing the system of care. In Vermont, a statewide training in dialogic practice was offered prior to a reorganization of the system of care in a way that would offer training participants clear routes to practice in accordance with dialogic principles. While in account of Smith (2022, p. 173), "Staff report a stronger emotional connection with colleagues and a feeling of being re-energized by working this way," these data may indicate that over time staff morale would increase to the extent that dialogic systems change offered dialogically trained staff the context in which such practice would be supported rather than against the grain. For example, if workers' responsibilities included dialogic practice rather than remained the same, where the expectation that dialogic work be done in addition to pre-existing job responsibilities. This theme, *CNA integrated into job descriptions/manageable workload* emerged as both an overlapping yet distinct theme with a saturation of 25. For example, a status quo in which staff continue to carry a full caseload of individual therapy or case management, and work over-time without pay to co-facilitate network meetings rather than revamping the system of care so that attending to networks is built in programmatically and integrated into job descriptions accordingly. Or psychiatrists primarily seeing clients in the context of network meetings rather than trying to squeeze in a network meeting to a full schedule of meeting with clients individually. Themes that were salient to achieving increased staff morale included: increased pay, increased staff, sustainable workload, working in pairs, and democratic and respectful inclusion of all staff.

Reduction of hierarchy was identified as a factor contributing to staff morale as exemplified by the following utterances: "all disciplines of staff are appreciated for their knowledge" and "trust emerged and can work as equals while in clearly defined roles." A dilemma that surfaces is how to both move forward in reorganizing the system of care to support and embody dialogic principles and be respectful and inclusive of all staff, some of whom are not in favor of this approach.

The theme of *culture change* [Collaborative Network Approach (CNA) Planning Committee, 2022] included transparency, dialogism, increased polyphony, and equality among staff, and a sense that change has been an organic process achieved by modeling and the accumulation of positive outcomes. While the theme of dialogic systems change overlaps with the theme of culture change, we see a difference between the two, where the first points to explicit decisions made to reconfigure the system of care, culture change embodies a more organic change process premised on influence and attraction rather than implementation. Expressions of *culture change include:* "Once staff noticed how beneficial it was everyone *wanted* to do it," "staff who are practicing show such integrity in what they say and do others are following," "values have leaked into youth and family," "there is *a* noticeable shift in how we are having conversations-nothing about me without me," "staff-wide acceptance of meaning of what patients are saying" and "day to day they [those engaged in services] feel responded to in a way that is rooted in dialogic work," and "OD is the first thing thought *of* as safety net, way of working, family of choice." One utterance that was particularly radical imagined a shift to the extent that staff no longer used texts or emails to communicate about people who were engaging in services—please let it be so!

Dialogic system expansion/systems change (Rosen and Stoklosa, 2016) was expressed as having achieved a high degree of responsiveness—same day access in outpatient settings, and CNA becoming the primary and initial way of responding to requests for service: "CNA is the modality that is mainstreamed for how to move forward (in every department)." In some cases, CNA was imagined as a specific team of dialogic facilitators ("established CNA team to facilitate meetings that respond immediately, mobile, offer psychological continuity"), while in other utterances, it was imagined that all staff had been trained and "CNA [is] part of everyday workday." Other utterances describing a vision of dialogic practice included: "We have really slowed down," "before the intake we are thinking about their community and network," and "[we have] fully embraced 'nothing about me without me." Being able to offer *person centered care* (Davies, 2008) was also high in frequency. This indicates the degree to which dialogic training touches on deeply held humanitarian values for training participants, and how morale is imagined to increase when being able to practice in alignment with these values. In outpatient settings, this was expressed as "power with instead of power over" network participants, and as network participants helping to shape the system change through co-research (Anderson, 1997). An utterance from CSAC included in this theme, "psychiatry as a small part of service not a driver of practice" exemplifies a shift from privileging the agency of the professionals to the agency of the person at the center of concern. The hope was also expressed that psychiatrists could participate in the dialog as a "human being" and not solely viewed through a psychiatric lens. At VPCH, the one inpatient setting, person centered care was primarily defined as offering "person-centered-rounds"—as distinct from rounds where the treatment decisions related to the person at the center of concern are discussed without their presence (Rosen and Stoklosa, 2016).

CNA Sustainability (Arnkil T. E., 2019) is related and yet distinct from issues of morale and workload. This theme is largely concerned with workers' experience of whether the practices of CNA will survive in their work contexts. Factors put forward to help staff be "less worried and more confident, [and have a] sense of ease that dialogic practice will be supported and working" included having many more staff involved so "we will not have to worry what happens if we lose two members of the team," and managers valuing dialogic work as evidenced by allocating time, resources and funding for it," to the point that CNA is stable enough so that leadership change (if they do not know about dialogic practice) will not threaten CNA."

Participants at all sites spoke to the theme of *training and supervision* (Arnkil T. E., 2019), the aims of which included: increasing the number of staff prepared to facilitate dialogic network meetings, familiarizing all staff with dialogic values and principles, embodying dialogic principles in varying contexts—such as residential settings, and increasing community awareness of these approaches. Training included both new staff orientation, community education, in-house training programs and setting aside 30 min of weekly staff meetings to do mini-trainings. Participants also spoke of offering on-going training that was accessible "at good times in their careers when they can also do the work"—further underscoring the link between training and the conditions in which it is possible to practice learnings from the training.

Prioritizing resources of natural supports (Seikkula et al., 2012) was also emphasized across all four sites, invoking a paradigm shift from individual-based to network-based engagement—it is the "norm for the network & the person at the center of concern to be engaged." Participants from VPCH envisioned person-centered rounds in which "natural supports and external providers participate in weekly network meetings." In an outpatient setting, a staff-person shared, "Before the intake we are thinking about their community and network." Rather than holding up medication as a solution, one community-based psychiatrist proposed that from the outset we "hear from the whole network and think together about what resources they already have and what we can offer." This theme encompassed both clients' pre-existing natural supports, and an orientation toward helping potentially isolated clients to foster new relationships in the community.

Increased access to CNA for clients/community (Seikkula et al., 2003) is closely linked to the system change theme and is highlighted because this aspect of system change was mentioned across outpatient settings. CNA was also envisioned as a way to respond to communities in conflict with one another. *Peer support and human rights* (Arnkil T., 2019) is also closely linked to systems change—and was spoken of in conjunction with the advocacy necessary to reconfigure agency leadership structures to include peer support workers, to hire individuals currently engaging in services at the agency, and to increase dedicated hours for peer support staff to facilitate network meetings. This theme is also inclusive of a systematized effort to outreach to people who have experienced involuntary hospitalization to offer network meetings with the aim of restoring trust, validating trauma sustained in the process for all parties involved and gathering learnings in the service of preventing future involuntary hospitalizations.

Working in pairs (Arnkil T., 2019), is linked to system change, staff morale, and sustainability. Working in pairs enables the reflecting process, tolerating uncertainty, flexibility, and responsibility. In addition, "people do not feel alone in their work" and can further deepen collaborative, trusting relationships (if all goes well!). *Inpatient/outpatient continuity* (Arnkil T., 2019) was expressed by both inpatient and community-based dialog participants with the idea that the outpatient team would be able to stay connected with the network during hospital stays.

4.1.2. Worries

When the participating organizations were asked what they were worried about, *lack of support from key decision-makers and/or leadership* (Seikkula, 2002) to support systems change was a key theme. "It could fall apart because it's supported by a small group of people" speaks to a sense of precariousness. Many participants expressed concern about losing momentum in this way of working in connection to lack of support and/or *low staff retention* (Bergström et al., 2018)—increased difficulty filling vacant positions as well as dialogically trained staff leaving positions. One respondent was concerned that "staff would not have the time, energy and passion necessary to make change" another shared, "People are so stressed and tired."

While these worries were frequently acknowledged, there was also a focus on *not wanting to risk overworking* (Seikkula et al., 2012) remaining staff by *piling more onto their existing workload* (Florence et al., 2020). "We can train people in OD but then they are running on fumes and that will run out without structural change." Another often-voiced worry, was the *lack of consensus among staff* within agencies about aspiring to the principles of open dialog (Anonymous, 2019).

Utterances along these lines included, "other staff would not agree to change [and] if they did not, neither would the system" and worry that the "influence of those who did not want to make changes [who held] priorities that were not patient-centered." This last worry has implications both for worries about the practice itself, the wear and tear of paradigm differences among staff and the extent to which being in a holding pattern with regard to a more wholesale systemic commitment to these practices decreases staff morale and resilience. It is worth noting that these dialogs were held during the pandemic and a time of increasing political and social polarization and its toll for many was felt both personally and professionally for respondents—*tough times* (Seikkula et al., 2003) gives additional context to worries about overworking staff, low staff recruitment and retention, and concerns about the deleterious effect of an ongoing lack of staff consensus.

4.1.3. What made change possible

When the participating organizations were asked what made changes possible, *offering and expanding dialogic training* (26), both within organizations and among the community, was the theme expressed across organizations with the highest saturation. This is related to other prominent subthemes, primarily the need for additional funding as well as increased implementation of dialogic practice in a context in which this practice is supported holistically. Dialogic practice in a context which is supported holistically translates to offering training and supervision to interested staff, integrating CNA into job descriptions so dialogic work is integrated rather than additive, and increasing collaborative teaming opportunities—for all staff, including psychiatry—to work in alignment with dialogic principles. The second most salient theme, *increased funding* (Arnkil T. E., 2019), was expressed as the need for higher pay, which was also connected to the frequent highlighting of the need for increased staff recruitment and retention. However, *increased funding* was also expressed as greater investment in training, investment, and financial support in novel ways of working, private insurance revenue paying for new CNA-specific positions, and Medicaid and private insurance reimbursement for dialogic practices. *Increased implementation* (Arnkil T. E., 2019) was expressed as hiring more staff with CNA-specific responsibilities, offering training and creating infrastructure to respond immediately, adoption of inpatient person-centered round, and adoption of dialogic intake program, moving toward being able to offer services without imposing a psychiatric diagnosis. *Support from key decision-makers/leadership* (Bergström et al., 2018) included utterances such as "division directors buy in," support from the state legislature, support from supervisors, leadership "talking about it until people relented." *Interested staff have more opportunities to participate* (Bergström et al., 2018) was expressed as opportunities for dialogic training and supervision, integration into work responsibilities, and psychiatrists and peer support workers being able to participate as meeting facilitators rather than their roles eclipsing their ability to be seen as facilitators. *Cross silo communication/teamwork* (Seikkula, 2002) was expressed as inter and intra-agency collaboration as well as cross-department, cross-agency, multidisciplinary trainings as a way of breaking down silos. Wellness as a collaborative project (Seikkula et al., 2012) was described as shared by staff for staff, as well as a joint project of the staff and the greater community, for example, having barbeques and engaging in "activities and events together with art and music."

4.1.4. What lessened worries

Support from key decision-makers/leadership for system change (Seikkula and Arnkil, 2006) would be necessary to make such integration possible. For example, "leadership supporting and allowing time to train and work with families." Participants expressed that *alignment of infrastructure and systems with dialogic practice* (Seikkula, 2002) and *integration of CNA into job descriptions* (Seikkula, 2002) lessened their worries. Such integration would be the corrective to overworking, working "against the grain" of the system, and tolerating the uncertainty of lack of clarity about the direction in which the organization is going; rather, participants envisioned practicing in a systemic context that was organized to support dialogic principles. *Having patience while staying engaged with this model* (Seikkula et al., 2003) speaks to the organic nature of dialogic processes—of tolerating the uncertainty of becoming. One respondent offered, "Faith that once enough people were exposed they would find it valuable and meaningful." Another recalled, "There was a tipping point and the fire spread on its own."

4.2. Limitations

A significant limitation of this study is that those of us who facilitated the anticipation dialogs have not undergone the 18-day standard of training in that way of working. This may have negatively impacted our ability to conduct the dialogs, our collective understanding of outcomes and explained some of our difficulties with pacing. Frequently, the authors hoped to have more time to engage in a reflective, dialogic, conversation with participants and to allow the participants to reflect on what one another shared. Timing was compromised at times due to accommodating arrival times and the need for participants to exit the dialog.

These dialogs primarily involved staff and did not significantly enlist those with direct experiencing of "being responded to" by our system of care. On the one hand, given the state of duress workers in our system of care were in at this time, it may have been harder for staff to have given voice to this aspect of the visioning process if more service users had been present, for fear that it was not appropriate to talk about the cost of working in the system of care. It may also be true, that if more service users had been present, this would have reinvigorated staff's commitment to dialogic practice, and informed how best to realize it based on the priorities expressed by service users. Perhaps, letting service users in on the worries held by workers in the system may have allowed more potential ways forward to emerge. Directions for future research might benefit from an anticipation dialog research project informed by the work of Soggiu et al. (2021) who describe a dialogic research process that privileges the role and voices of service users throughout.

There are many overlapping relationships and dual roles in the state of Vermont, for instance, two participants from HC involvement in the CNA statewide planning group with one author of this research. Social and familial relationships exist across agencies and within the community. Often, this interconnectivity is seen as a strength; however; it may have influenced the way participants responded to one another in having deeper awareness of the potential impact of their responses on their colleagues.

All three of the researchers work or have worked at CSAC and were either in the inner or outer circle of the AD as participants. All

three of the researchers have been involved in the statewide training as trainees and either trainer or trainer in training. One author of this research was in a workplace supervisory role of the two other authors for the majority of the duration of the research project.

We conducted anticipation dialogs with each organization separately and so each organization was unable to hear and/or respond to the utterances of one another. The context of when these dialogs took place is important to address in that many of the organizations were in the midst of an extreme staffing crisis. The number of participants from each organization was not equal which impacted the representation of utterances unevenly throughout the data. The Counseling Service of Addison County in particular had more participants.

The COVID-19 pandemic, increasing economic distress, and social/political polarization were an ever present influence that deeply impacted working practices at all agencies involved in this study. How these contextual factors were brought to bear on the visions, hopes, and worries expressed within the anticipation dialogs can only be speculated upon. However, it is notable that *increased morale* was the most saturated among delights (27). The specter of these larger world events and socio-political currents have also acted upon the authors of this study, influencing our own morale and the lens through which we have interpreted the data and experienced the dialogs.

It could be argued that rather than being at an impasse, our system—and those of us working in it—was/were in a state of crisis at the time of this research, and that it is open dialogs rather than anticipation dialogs that are called for in moments of crisis (Eriksson and Arnkil, 2009).

4.3. Implications for practice

In their study of the evolution of CNA, Florence et al. (2020, p. 688) note, "The combination of working from the ground up, determining how to incorporate network meetings within agencies and having support from the system more broadly were described by participants as key features of the Vermont experience." These dialogs demonstrate a vision for change in Vermont's system/s of care to increase the extent to which dialogic work is the norm rather than the exception in how we respond to people seeking support. Each setting has its own particular vision and path in this regard. However, across site, the following common themes emerged as far as what would make change possible: clarity and more decisiveness from agency leadership and DMH in systemically committing to dialogic principles, integrating CNA into workers' roles and duties, staff recruitment and retention, reducing hierarchy and continued training.

These are noticeably interdependent. For training to be a worthwhile investment, there must be low-turnover. To retain staff and increase morale, it is important to have a clear vision, room for staff to co-create the vision, and have workloads that are reasonable and purposeful. To recruit and retain staff engaged in dialogic work, they must make a live-able wage which requires a systemic commitment from DMH, agency leadership, and the state and national legislature. The human service staffing shortage is a complex issue and not one that has easy answers.

While anticipation dialog participants shared that dialogic practice offers an increased sense of meaning and joy in working together, this in itself needs to be complimented by additional factors to retain staff. Staff retention is pivotal in the sense that if agencies invest in training staff they remain in the public sector. Training needs to be offered in connection to a CNA-specific role in which the principles taught in training can be utilized and supported. Taking on dialogic work in addition to one's job description risks leading to burnout and reduces the sustainability and growth of these practices. Making dialogic practice an explicit part of someone's role and not an additive, evolving a systemic context that supports these roles are key to sustaining staff who have come to embrace dialogic work. These themes are connected to the expressed hope for system change and the necessary financing of such change. Funding would need to be expanded and reallocated to support CNA-specific roles, expanded training opportunities, and staff pay increases.

Reducing hierarchy and increasing democracy, collaboration, and inclusion was often expressed as a vision for the future. This again highlights the dilemma of how leadership can be more proactive and decisive about making changes in the system of care, while simultaneously fostering a less hierarchical and more democratic workplace. The dialogic principles have the potential to anchor us, yet a focus on them may also call attention to divergent values among staff thereby heightening tensions in the workplace (Florence et al., 2020)—especially if in order to participate in dialogic work, staff need to do so above and beyond their explicit work responsibilities. Relatedly, staff across the agencies pointed to the significance of staff morale, staff inclusivity, the joy of working together, being part of a meaningful community in which there is mutual respect and interconnection. The high saturation of these themes points to how sensitive staff are to each other. People working together are often sensitive to how connected or disconnected they feel to one another and being in conflict can be difficult. These principles and this way of working therefore can influence morale for better or for worse. This also raises the question of whether tensions experienced between staff with differing relationships to dialogic practice are exacerbated by prolonged uncertainty about whether or not a workplace is shifting toward a dialogic framework, without clear signals and plans from leadership.

As mentioned, dialog participants frequently voiced the hope for system change in a strategic and coordinated way. It is possible that dialogic practitioners having a more regular audience with the department of mental health would improve communication and clarity about making systemic changes, and asking more directly for DMH's support in creating funding mechanisms and other adaptations so that DMH's substantial investment in training is more efficiently channeled into practice, and so that staff are not in the dissonant position of learning a new practice that can be experienced as being a square peg in a round role. This may be easier said than done, for as Florence et al. (2021) point out, it may be "better to start somewhere and gradually take up other elements that can be harder to integrate in a system that operates in an antithetic way" to dialogic principles.

As far as we are aware, this is the first time a study has been conducted on the experience of integrating dialogic principles in a multi-agency system of care utilizing anticipation dialogs. When we decided to offer these dialogs, it was with the intention that they might increase a sense of hopefulness, momentum and energy during a chaotic and strained time. We invoked the idea of crisis as opportunity—and we were in the thick of it. There is a feeling now of being able to see the light at the end of the tunnel. In January of 2022, the United Counseling Service launched the dialogic rapid access

intake project hinted at in the anticipation dialog of 2021. In September 2022, the Vermont Psychiatric Hospital adopted person-centered-rounds envisioned in October 2021 on one of their units. CSAC launched a dialogic rapid access intake program inspired by UCS in October 2022 and plans launch a hospital diversion program integrating open dialog and intentional peer support in early 2023. The Howard Center has created a new position entitled the Coordinator of Peer Support and the Collaborative Network Approach. The Vermont Department of Mental Health, and CNA leaders a participating agency are in the process of creating a workgroup to identify and attend to barriers to realizing dialogic practice within the statewide system of care [Collaborative Network Approach (CNA) Planning Committee, 2022]. While we cannot presume that the anticipation dialogs that played a role in these developments, it is worth noting. As such, anticipation dialogs may be a way of conducting systemic research that contributes to the forward momentum of system innovation.

It is hard to keep from wondering what these dialogs might have yielded if they had been conducted prior to the outset of the pandemic and the acceleration of a staffing crisis in our system of care. Concerns about sustainability of CNA practices are in a larger context of staff uncertainty about the integrity and longevity of our public system of care as a whole. Rather than arriving at a comprehensive list of actionable items of how we might advance the particulars of dialogic practice, we find ourselves needing to address the more global issue of finding and retaining staff. That said, even prior to the pandemic, staff have spoken to the difficulty of being in a drawn out holding pattern in which, once having become energized and inspired by the dialogic training process, they attempt to practice in ways that increase their workload without a clear commitment from leadership to make systemic changes in accordance with these principles. While at the beginning of Vermont's inquiring into and gaining experience with dialogic work holding, some uncertainty about how this would be borne out was tolerable, and perhaps necessary as a way to protect a needs adapted rather than a more standardized approach to open dialog, as the years go on, the uncertainty may be at a cost to sustainability. How can decisions be made regarding the advancement of dialogic practice in Vermont in a way that is in keeping with being inclusive, democratic and non-hierarchical? The seven principles of open dialog (immediate response, responsibility, flexibility, psychological continuity, a network perspective, dialogism, and tolerating uncertainty) are interdependent in their work to support a network's journey through a transitional and chaotic period. In both therapeutic and organizational change processes, a balance is needed between the open-endedness of possibilities, and the safety and stability of a team taking on their share of the responsibility for holding the process (Lennon et al., 2022). We are left encouraged by participant motivation to continue on this path with hopes that this paper may contribute to striking a sustainable balance.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the corresponding author (ZA), without undue reservation.

Ethics statement

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The patients/participants provided their written informed consent to participate in this study.

Author contributions

ZA, SB, and AO contributed to the conception, design, data collection, and data analysis and contributed jointly to the initial write-up of this study submitted as a paper required to graduate from Dialogical Approaches in Couple and Family Therapy Psychotherapy Trainers Training sponsored by the University of Jyväskylä. The manuscript for this article was primarily drafted by ZA drawing a great deal from this paper. All authors contributed to the article and approved the submitted version.

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As stated, all of us worked at the Counseling Service of Addison County for the majority of the duration of this study. However, anticipation dialogs conducted by ZA, SB, and AO, as well as the analysis of the dialogs occurred outside of paid work hours. One author did use 1 day of paid educational leave to complete edits on this article.

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Conflict of interest

At the time this research was conducted, ZA, SB, and AO worked at the Counseling Service of Addison County (Vermont, United States), one of the sites included in the study. One of the authors (ZA) is also the coordinator of Vermont's Collaborative Network Approach (CNA) State-wide Planning Committee. ZA, SB, and AO have participated as trainees and trainers in the CNA State-wide Training.

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Open Dialogue in Spain: an initial survey of knowledge and perspectives

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In Spain, the introduction of the Open Dialogue framework is relatively recent. This study takes a closer look at Open Dialogue training, interest and research in this region. To this end, a survey has been conducted through a convenience sample of professionals, people with their own experiences in mental health, family members, relatives, university professors and students. The results showed that a significant number of participants had no training in OD, and their exposure to relevant literature and congress attendance was limited. Amongst the different profiles, professionals reported the highest level of training. These findings highlight the urgent need for further research and training initiatives to improve the understanding and application of the OD framework in Spain. Efforts should be directed towards broadening the knowledge base, increasing access to training programmes and fostering interest amongst different stakeholders. By addressing these gaps, the implementation and use of OD can be expanded to meet the growing demand and interest in this approach in the Spanish context.

KEYWORDS

Open Dialogue, implementation, mental health, new perspectives in healthcare, psychotherapy training

1. Introduction

In recent years, there has been a growing interest and a gradual introduction of the Open Dialogue (hereinafter, OD) framework as an alternative treatment approach in Spain. Originating in Western Lapland in the 1980s, OD has demonstrated significant success in reducing the incidence of psychosis, achieving a remarkable decrease from 33 to 3 cases per 100,000 inhabitants over the course of a decade (Seikkula and Arnkil, 2016). The effectiveness of this intervention is primarily due to the basic principles underlying the OD framework, which can be summarised as follows (Seikkula et al., 2006, 2011): First, the provision of immediate help, within a 24-h timeframe following a request for help. In addition, networking plays a key role in OD, including family members and community members who can contribute to the well-being of the person seeking support. In addition, OD offers considerable flexibility in treatment, allowing adaptations to be made to meet the specific needs of each individual. In addition, the collaborative nature of OD is exemplified by professionals working together as a team, usually consisting of two to three members. Long-term continuity of care is emphasised, with follow-up and treatment extending over a minimum period of two to three years. In addition, OD encourages the cultivation of tolerance for uncertainty, discouraging hasty

decisions such as urgent hospitalisation or excessive reliance on medication. Finally, OD meetings are characterised by the principles of dialogue, ensuring active participation and equal voice for all members involved.

This OD approach bears remarkable similarities to mutual support groups, as highlighted by Chmielowska et al. (2022) and Lorenz-Artz et al. (2023). Its adoption extends beyond Spain, as evidenced by its use in several countries, as reported by Buus et al. (2021) and Mosse et al. (2023). Although the adoption of OD in Spain is relatively recent, significant progress has been made. In 2016, it was first used as a tool in the Mental Health Centre of Badalona (CSM Badalona 2), specifically to support recovery processes, following a pilot experience (Vallverdú et al., 2019). Subsequently, in 2017, the health authorities of the Community of Madrid approved and promoted the use of OD as a therapeutic framework and organisational system in the Early Attention Unit for Psychosis (UAT) of the Príncipe de Asturias University Hospital in Madrid. However, the continuity of OD implementation in both centres faces challenges. In Badalona, the retirement of the person in charge, Dr. Jordi Marfà, has affected the continuity of the service, whilst in Madrid, changes in the team and the sick leave of the promoter, Silvia Parrabera, have resulted in a limited number of cases being treated from an OD perspective.

In particular, OD practises have also emerged outside the public system. Some associations, groups and collectives, such as *Laporvenir*, have developed their approaches based on the OD framework. Several of the founding members of Laporvenir were previously part of the UAT team at the Hospital Universitario Príncipe de Asturias, together with other institutions (see Parrabera, 2017). Although the association is facing economic difficulties, it continues its activities (more information can be found on its website: https://laporvenir.org/).

The emergence of new evidence highlighting the need to reassess the development of mental health systems, programmes and services is not unique to Spain. It is a trend that can be observed in Spain as well as in other European countries (Martín López-Andrade, 2015; Correa-Urquiza, 2017; Desviat, 2020; Huertas, 2020; Fernández Liria, 2022). These calls for reassessment highlight the importance of exploring alternative approaches, such as OD, to meet the evolving challenges and demands in the field of mental health.

The detrimental consequences of psychiatric diagnoses (Hyman, 2010; Colina et al., 2021), the increasing violation of rights within mental health services (Muñoz Escandell, 2021), and the limitations of a vertical, unidirectional model of care with limited emphasis on dialogue (Martínez-Hernáez, 2000) all highlight the need for transformative change. Desviat (2020) points out that the psychiatric reform of the 1980s was not a revolution, but a carefully negotiated transition involving psychiatric authorities from the dictatorship era who held influential academic and clinical positions, this reform did not fundamentally change the existing dynamics. However, the current context underlines the urgent need for change that recognises the inherent complexity of mental health problems and the associated social distress (Kleinman and Kleinman, 2000). Desviat (2020) advocates a 'renewed clinic' that includes essential elements such as continuity of care, therapeutic accompaniment, crisis intervention, home hospitalisation and the formation of transdisciplinary teams.

In this context of renewal, OD emerges as a transformative approach to the provision of care and support, with a strong emphasis on cultivating relationships based on complicity, proximity and compassion. It advocates dialogue and the deconstruction of hierarchical approaches to treatment, actively involving additional actors such as family members, neighbours or friends in the processes of therapeutic recovery. OD is based on the fundamental premise that mental health care is a collaborative and multidimensional endeavour that prioritises the reconstruction of relational aspects and the life trajectories of individuals, rather than focusing solely on pathology (Fernández-Villardón et al., 2022).

The implementation of OD in Spain is characterised by regional differences. In some cases, professionals have incorporated OD into their individual practises or integrated it with other existing methods, such as multifamily group therapy (Sala, 2020; Sempere and Fuenzalida, 2021; Oujo-Fernández et al., 2023; Sala, 2023) or contextual therapies, including acceptance and commitment therapy. In the latter case, however, the integration is more theoretical than based on specific training in OD (Díaz-Garrido et al., 2023). In addition, the involvement of experts with lived experience is a common practise within the care team.

The growing momentum of OD is in line with the need for a paradigm shift in the approach to mental health care, not only in Spain but also globally in the Western world (Hyman, 2010; Martín López-Andrade, 2015; Correa-Urquiza, 2017). OD has emerged as a response to the limitations and chronic effects of conventional biomedical treatments. It also reflects the dissatisfaction expressed by individuals with lived experience and professionals themselves, who feel constrained by distressing institutional dynamics that prioritise harm reduction through the use of psychotropic drugs and prevent the coherent implementation of their principles in meeting people's needs (Tsou, 2007; Hyman, 2010; Beresford et al., 2016).

In Spain, people with lived experience of mental health services report the need for social change at all levels of the health system to include more supportive practises, fairness and respect for biocultural diversity (Hyman, 2010; Correa-Urquiza et al., 2020). This highlights the need for a cultural shift towards a more democratic and humane approach that recognises mental suffering as a multifaceted reality that requires careful consideration of its inherent complexity. Furthermore, changes in the working conditions of healthcare professionals are crucial to enable a more psychosocial approach and effective coordination that avoids isolating individuals from their unique circumstances (Tizón, 2013, 2014; Seikkula and Arnkil, 2016; Seikkula and Arnkil, 2019).

In response to the changing landscape of mental health care in Spain, OD is gaining relevance as an approach that meets the expectations of both professionals and individuals experiencing mental distress. Its value lies in its potential to reorganise the mental health system and transform professional practise through its open and flexible methodology. In addition, OD has the versatility to be applied in other community organisations. The growing interest in OD was exemplified by the recent 26th International Congress of the OD Network for the Treatment of Psychosis, held in Spain in 2022, which marked an important milestone for the OD approach.

Regarding training, which is fairly recent, first offered in 2020 as a University Expert Course in OD: Fundamentals were developed at the Universitat Ramon Llull in Barcelona (20 ECTS, 500 h), led by Dr. Berta Vall Castelló. The course had a first edition, but did not continue perhaps due to the economic cost, as it was a face-to-face course with several international speakers. An online course of 150 h of duration was launched in 2022 at the University of Almeria, which covered all its initial places (45) and is now preparing its reedition and the possibility of continuing this first promotion with a Level II (trainer of trainers). This course is co-directed by Jaakko Seikkula himself.

Thus, there have been some attempts to promote OD training and practise in Spain, but with various difficulties. What has not been carried out so far is a study on the opinion of people who had contact with OD in order to better understand their assessment of what this training entails and the changes it can represent in mental health in Spain. This study aimed to fill this gap.

2. Materials and methods

2.1. Participants

The target population was a convenient sample of professionals, people with their own experiences in mental health, family members, relatives, university professors and students. The recruitment was made by disseminating the link to the survey carried out in google forms, sharing the link in different instant messaging groups and through social networks. The inclusion criteria were to belong to one of the five groups mentioned above, regardless of age or previous OD experience.

2.2. Instruments

For data collection, a survey was designed collecting socio-demographic data (age, gender, level of studies, current occupation) and, subsequently, different questions related to:

1. Degree of knowledge of OD
2. OD training received
3. Possible implementation of OD
4. Participation in OD

The survey can be consulted in the Supplementary material. Likewise, when answering the questionnaire, participants could select one of the following profiles, leading to a series of questions about their experience with OD:

A. People with own experiences in mental health
B. Close friends / Environments
C. Mental health professionals
D. Public mental health system managers / associations with experience in OD
E. University lecturers
F. University students

To end with, an open question to the participants was included, namely "Finally, we welcome your thoughts, ideas, comments, observations, opinions on OD in Spain."

2.3. Procedure

The aforementioned survey was designed and published using Google Form. A brief summary on the nature of the study was included at the beginning of the survey explaining it was anonymous and completely voluntary, and that participants could stop completing the questionnaire at any time. In addition, a contact point with the researcher team was provided. The questionnaire took between 15–20 min to complete. The study was approved by the Bioethics Committee of the University of Almeria (UALBIO2021/013).

Convenience sampling was used to gather participants, sending the form to the researchers' databases containing people who had been in contact with OD, either because they had been involved in a clinical process based on OD or because they had undergone training. In order to avoid double entries for the online questionnaire response, the restriction of sending only one response per registered email was used. It was equally disseminated on social networks and WhatsApp groups to which the research members had access. No follow-up was carried out for those who did not respond to the survey.

2.4. Analysis

Descriptive statistics were calculated for the population. Subsequently, the responses obtained for each of the proposed questions on knowledge of OD were analyzed, obtaining frequency and distribution statistics for each of these variables. The different analyses were carried out using the SPSS statistical package in version 25.

3. Results

3.1. Descriptive statistics

A total of 214 people (147 women and 67 men) participated in the present study. The ages of the participants ranged from 18 years to over 70 years of age (55% of the population is between 30 and 49 years of age). Descriptive data on the participants were according to the four age brackets proposed as possible responses, we found from oldest to youngest with 4 participants aged 70 and over; with 29 people aged 60 to 70; a total of 33 subjects aged 50 to 59; another 61 people aged 40 to 49; with 60 participants aged 30 to 39; and, finally, 35 respondents aged 18 to 29. In terms of educational level, 87.4% had completed university studies.

Table 1 shows the distribution of the sample in terms of the six profiles collected, and whether they have received training in OD (40.19%) or not (59.81%).

Table 2 shows the time spent on training in OD, according to the profile of the participants. In this case, it can be seen that the profiles of public health managers and university professors have the highest rates of training in OD (80%) and, in third place, the profile of health professionals with 44.29% of these having undertaken some type of training in OD. However, this training has been limited in time, as only 16 people out of the total sample received more than 100 h of training (i.e., 12% of the total number of those who received some type of training).

Table 3 shows the distribution by country of origin of the training received by the participants. It can be seen that the majority was in Spain (almost 90%), with 4 people having received training in Argentina or Uruguay, 3 in England and 1 in Mexico.

Table 4 includes frequency statistics of the participants who received some kind of training in OD, the year in which they first heard about OD, also the readings they have done on OD, attendance at talks or conferences on OD, and, finally, whether they have participated in any group or association to use OD as a

TABLE 1 Descriptive statistics on profiles.

Profiles	*N*	NT	NT %	WT	WT %
People with their own experiences	29	20	68.97	9	31.03
Close friends / Environments	30	25	83.33	5	16.67
MH professionals	140	78	55.71	62	44.29
Public MH System Managers / Associations	5	1	20	4	80
University teachers	5	1	20	4	80
University students	5	3	60	2	40
Totals	214	128	59.81	86	40.19

Use: NT, No training in OD; WT, With training in OD.

TABLE 2 Training time in OD in hours.

	0 h.	1–5 h.	5–30 h.	30–100 h.	100–300 h.	+ 300 h.	% child h.
People with their own experiences	20	3	3	3	0	0	31.03
Close friends / Environments	25	2	0	2	0	1	16.67
MH professionals	78	10	22	15	13	2	44.29
Public MH System Managers / Associations	1	0	2	2	0	0	80
University teachers	1	0	3	1	0	0	80
University students	3	0	1	1	0	0	40
Total	128	15	31	24	13	3	40.19

TABLE 3 Origin of the training received.

	N	%	% Accumulated
Spain	68	89.47	89.47
Argentina-Uruguay	4	5.26	94.73
England	3	3.95	98.68
Mexico	1	1.32	100
Total	76	100	-

resource for support. As can be seen, practically all the people begin to know about OD from 2020 onwards, except for mental health professionals, who indicate 2018. The number of readings on OD is also higher in professionals (7.73) and lower in the rest of people, as well as attendance at talks or organisation of sessions on OD, which is once again much higher in mental health professionals.

3.2. Qualitative analysis of the reflections on the OD in Spain

Using a method of syntactic analysis of the responses to the question "Finally, we would like to thank you for your thoughts, ideas, comments, observations, opinions on the OD in Spain," four main blocks or central themes were identified: (1) Benefits of OD, (2) Lack of training, (3) Need for research, and/or, (4) Need for changes in the public mental health system.

With regard to the first category, we find that the participants highlight the importance of being able to rely on this methodology in treatment, emphasising the need for humanisation, normalisation of the experiences and the monitoring of cases in a much closer and less traumatic way, both for the user and for the people or family members around them. As textual evidence recovered from the responses, the following can be cited:

> *"Very interesting type of therapy. The user and the family feel well supported. The results are evident for everyone"* (Woman, retired, 111).

> *"I think it is a very interesting new treatment conceptualisation especially in psychotic patients that can reduce psychiatric admissions, as well as better link patients"* (Female, health, 127).

As for the second category, reference is made to the lack of training in OD in Spain. The possibilities and potential of OD are commented on, but also the need for courses or specialised training in the participants' work centres to facilitate its implementation within the public mental health system. In this sense, the following reflections were made:

> *"It is difficult to find where to get training"* (Woman, health, 28).

> *"It seems that more is beginning to be known and disseminated, but knowledge is still very scarce, and there are many female workers within the MH system who would like to work with a different methodology that is more coherent with their values, and that does not put them in uncomfortable situations that take away agency from the people they care for"* (Woman, health worker, 45).

Thirdly, there is a need for more research in OD for its dissemination and the expansion of knowledge about the impact that this methodology

TABLE 4 Knowledge and application of OD.

	Year of knowledge OD	Numbers of OD readings	Numbers attendance talks	Organisation of sessions in OD
People with their own experiences	2020 ($n = 7$) 2022 ($n = 2$)	4,2	3,6	1
Close friends / Environments	2020 ($n = 5$)	5	0	0
MH professionals	2018 ($n = 41$) 2020 ($n = 14$) 2022 ($n = 7$)	7,73	6,19	7
Public MH System Managers / Associations	2020 ($n = 4$)	1,3	2,3	0
University teachers	2021 ($n = 4$)	2,7	3,5	0
University students	2020 ($n = 2$)	1,3	2	0

With regard to the perception of the need for a change in the care model of the public mental health system, results showed that 85% of those surveyed are in favour of changes, compared to 1.4% who think that changes are not necessary, and 13.6% who do not know/do not answer.

of care for mental health users could have on the course of crises and care for both patients and families during their recovery process.

> *"Publicity campaigns and good marketing are needed to make it known, as well as research studies that accredit and endorse it in a generalised way"* (Mujer, sanitaria, 52).
>
> *"Need to publish studies to promote its application in public settings"* (Woman, health, 72).

The fourth and last category contemplates the need for changes in the public mental health system, for the inclusion of new approaches and ways of treating and monitoring people with serious mental disorders. It is essential to make changes and promote new health practises in order to really achieve greater progress within the public mental health systems and to evolve towards new horizons with more optimistic perspectives.

> *"I don't really know how well established it is, its current situation, but I feel that a change in the way we look at mental health is necessary. Our society is governed by a rigid scheme based on scientific knowledge that generates stigmas, labels … closing off possibilities, not allowing us to see what person we have in front of us. OD and its dissemination can help to change this view"* (Woman, health, 35).
>
> *"The public health system is still far from being able to incorporate models based on collaborative and dialogic practises"* (Woman, health, 123).

4. Discussion

The aim of this study was to evaluate the assessment and knowledge in Spain, a country where the first dialogic practises have recently been implemented, being important the holding for the first time in Spain the 26th International Congress of the OD Network for the Treatment of Psychosis in 2022.

The data obtained indicate that in the sample consulted there is a strong interest in a change in mental health, where OD can be a promising alternative, albeit there is still little knowledge about this framework. Thus, a significant percentage of respondents (almost 60%) indicate not having received any training on this approach, with the majority of those who have had some kind of training having received less than 100 h. This probably relates to the fact that there are few training possibilities in Spain, where there was only an initial course in 2020 at the Universitat Ramón Llul en Barcelona, which was not followed up, and another one recently at the University of Almeria. Nevertheless, the latter has sold out and is currently being considered for reissue, as well as the extension of the training to a Level II (trainer of trainers), thus that the impact it can have on mental health in Spain is likely to begin to be felt soon. This aspect, the training, seems to be key for OD to really bring about a real transformation in mental health in Spain.

The number of readings on this approach was low. The available readings in Spanish on this topic are also scarce, where there are hardly any articles or book chapters, concentrated in the last five years (Parrabera, 2018, 2019; Vallverdú et al., 2019, 2020; Abad and Toledano 2022; Oujo-Fernández et al., 2023; Parrabera-Garcia and Chico, 2023), with the exception of one work (Abad et al., 2015). Similarly, the majority of respondents indicate that they have only heard about this topic three years ago (since 2020). Only healthcare professionals are the ones who have heard about OD a little earlier (since 2018) and have read more or attended talks or conferences on this topic.

There is a high level of interest in the institutional recognition of OD as a legitimate practise and perspective for addressing mental health in the consulted sample; it is also essential to start applying to other community organisations in order to generate a social transformation and a cultural change (Seikkula and Arnkill, 2019). In this sense, although there are seminars and small training proposals, there is a clear need to broaden and deepen the creation of systematized and organised training. In this sense, 85% of respondents expressed the need for a paradigm shift in Mental Health, which can be linked to the mandate of the "United Nations Convention on the Rights of Persons with Disabilities" (2006) and the successive reports of the UN Special Rapporteurs in defence of these rights. The OD can be deduced as one of the possible methodologies for the materialisation of the transition (World Health Organization, 2021).

These results are similarly observed in the qualitative evaluation, where participants highlight the benefits of OD, the absence of training, the need for research and the importance of changing the public health system. Thus, it is true that there is hardly any research carried out in Spain, beyond describing some experiences of initial practise sites (Minondo Romeroa et al., 2022), but no funded projects in this area have been found, nor active participation in other international studies, such as HopenDialogue (https://www.hopendialogue.net/).

It is necessary to develop also more local research that measures and analyses its effectiveness, taking into account the socio-cultural particularities of the country's context and territory. It is therefore necessary to analyse local casuistry in the implementation of the OD in order to produce evidence that allows us to evaluate the development and implementation of the model. Depending on these results, the possibility of endorsing the OD framework as a treatment option within the public MH system, and as specialised training in universities and scientific societies, could be considered.

In addition, the critical situation of the biomedical model in the field of mental health, promotes the urgency of new paradigms, practises and methodologies that accommodate the necessary transformations to generate a model attentive to the inherent complexity of the phenomenon of mental suffering. It is in this context that, for professionals, users and family members, OD appears as a possibility that, although it does not take into account the multiple dimensions related to this field, it is understood as a cornerstone on the road to the necessary transformations. It is an internationally legitimised possibility (World Health Organization, 2022) whose value lies, in turn, in the capacity at source to measure and analyse the impact of the model. In other words, the capacity of those who started with the OD to produce evidence of the results of its implementation is one of the key aspects of its international legitimacy.

Nevertheless, this study has some limitations such as the small sample size, particularly amongst some sectors. As a future line, it is considered important to repeat the study in the coming years, to see if knowledge of this approach improves and if this framework becomes established in clinical practise.

5. Conclusion

The present study analyses the knowledge and appreciation of OD in Spain by a sample of participants who have mostly had contact with this approach., where the most of the participants highlight the need for change that can be brought about by adopting the OD framework in our country, but also identifies a series of shortcomings, such as the need for more research, the few readings consulted by most of the participants and also a need for more training, particularly long-term training, which could make it easier for people interested in the subject to become involved in this change. It should be borne in mind that the introduction in Spain is still very recent, for example, the two most important training events that have taken place so far, both in 2022, are very recent, such as the 26th International Congress of the Open Dialogue Network and the first promotion of the University Expert in Open Dialogue in Mental Health at University of Almería has just finished, therefore it will be important to continue evaluating its implementation and their repercussions in the coming years, as well as new training, clinical and research experiences that will be carried out.

Data availbility statement

The original contributions presented in the study are included in the article/Supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving humans were approved by Bioethics Committee of the University of Almeria (UALBIO2021/013). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

SP-G, CO-F, AC and EG-T: conceptualization and visualization. AC: supervision. EG-T and M-JL: methodology and Validation. AC, SP-G, and EG-T: resources. SP-G, CO-F, M-JL, AC, JM-V, MC-U, and EG-T: investigation and writing—original draft preparation. AC, M-JL and MC-U: writing—review and editing. All authors read and agreed to the published version of the manuscript.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

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Introducing Open Dialogue as part of the WHO QualityRights Project in South Korea: experiences and opinions from an introductory workshop and 1-year pilot practice

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This study explores the subjective experiences of participants in a 5-day Open Dialogue (OD) workshop and a 1-year pilot practice, conducted as part of the WHO QualityRights Project in South Korea. Twenty-four participants, selected through purposive sampling, completed surveys immediately after the workshop and 1 year later. Data were analyzed through both statistical and thematic approaches. A statistically significant decrease in the availability of "Flexibility and Mobility" was observed across all participants ($p = 0.044$) and a significant reduction in the availability of "Tolerance of Uncertainty" ($p = 0.04$) was noted among participants who engaged in network meetings over the course of 1 year. Qualitative analysis revealed that participants initially felt ambivalent toward OD due to systemic, cultural, and professional challenges. However, through experiential learning, their ambivalence shifted to hope, fostering solidarity and a more positive outlook for future OD practice. Participants recognized that implementing OD supported human rights, while addressing personal, organizational, and policy challenges. The findings provide important insights for developing OD training and implementation guidelines in South Korea. Recommendations include focusing on experiential learning and selecting mixed-group trainees from catchment area institutions, emphasizing the support of client rights, and considering individual, organizational, and systemic levels for successful implementation. This study represents a new case of OD dissemination through a top-down national research and development project and its integration into the WHO QualityRights service package, suggesting complementary potential between OD and global human rights-based mental health initiatives.

KEYWORDS

Open Dialogue, WHO QualityRights, human rights, recovery practice, person-centered, Open Dialogue training, implementation of Open Dialogue

1 Introduction

Open Dialogue (OD) is a system of mental healthcare developed in Western Lapland, Finland. Two essential ingredients of OD are the therapeutic and philosophical approaches to being with people in times of crisis or need; OD is also a way of organizing mental health services that maximizes the possibility of being able to respond to people (Jackson and Perry, 2015; Putman, 2021b). OD incorporates aspects of individual psychodynamic therapy and systemic family therapy, with a focus on the centrality of relationships and the promotion of connectedness through family and network involvement (WHO, 2021, p. 9).

Over the decades of its evolution, seven key principles of OD (Seikkula et al., 2001) have emerged: (1) immediate help; (2) social network perspective; (3) flexibility and mobility; (4) responsibility; (5) psychological continuity; (6) tolerance of uncertainty; and (7) dialogism. The first five principles are concerned with the structure of the service, and the last two with the form of practice; in reality, all of the principles are interrelated and depend upon each other (Seikkula and Olson, 2003). Therefore, in the effective implementation of OD, practical skills and teamwork are necessarily linked to how service systems are coordinated.

In a 2018 register-based cohort study conducted in Finland, the outcomes of OD were evaluated in comparison with a large nationwide control group covering a timespan of ∼19 years. The duration of hospital care, disability allowances, and the need for neuroleptic medication remained significantly lower in the OD cohort (Bergström et al., 2018). Further, it has been noted that OD participants tend to have better employment outcomes than those treated conventionally (Seikkula et al., 2006). Another national 5-year cohort study found that the Western Lapland catchment area had the lowest figures in Finland for the duration of hospital treatment and disability pensions (Kiviniemi, 2014). Qualitative studies also found that people using the service felt positively about it, along with the families and professionals involved (Tribe et al., 2019).

The World Health Organization (WHO) has developed and disseminated the QualityRights initiative, which uses a multi-component framework and strategies to promote mental health systems, services, and practices that prioritize respect for human rights in line with the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) (Funk and Bold, 2020). In the progress of this project, the WHO has listed OD in its guidance on community mental health services, promoting person-centered and rights-based approaches as best practices for mental health crisis response services (WHO, 2021, p. 27). In the context of these impressive achievements, OD has spread across countries and is growing rapidly, with more than 100 centers in 24 countries on five continents offering this approach (Pocobello et al., 2023).

1.1 OD: diversity in initial introduction in different contexts

There is still no mental health system outside Western Lapland in Finland, where the seven principles of OD are fully implemented (Buus et al., 2017), likely due to differences in existing service delivery and collaboration systems across countries. Therefore, there has been research on practices and a growing discourse on how OD has been implemented in different countries with different mental health systems (Pocobello et al., 2023).

Despite these differences in context, a common thread in OD adoption across countries is that the first step is to introduce training programs to equip service providers with the skills needed to implement OD. Nowadays, many countries generally introduce foundation training in OD for their service workers, with durations ranging from 16 to 20 days (Putman, 2021a).

However, there are several examples of shorter introductory workshops or short-term trainings as a preliminary step to full-scale training. This may be a viable way to introduce and spread OD when there is still a lack of social consensus for full-scale training and implementation and the necessary time, funds, and policies are lacking.

A study of participants at an OD conference in the UK found that while many agreed with the potential for positive changes in terms of clinical values and teamwork, implementation would require a commitment of resources and a shift in professional attitudes and service culture (Razzaque and Wood, 2015). Meanwhile, a study in Australia found that even participants in a fairly short 42-h OD training and pilot reported that the "different" learning experience they had received changed their perspective on therapeutic approaches and strengthened the bonds among them (Buus et al., 2023). Additionally, the experience of implementing the short training in two public health organizations suggested the need for a shift in organizational culture and leadership to become more relationship-oriented (Lennon et al., 2023). A study of a pilot after a short period of training in a psychiatric inpatient unit in the US suggested that this approach was effective in increasing the efficiency of daily clinical activities, improving patient-provider communication, and creating a more patient-centered care environment (Rosen and Stoklosa, 2016). A study of a group of mental health professionals who experienced only a short OD online workshop with no formal training reported that the dialogical approach of regular supervision over a significant period of time had numerous meaningful impacts on both the participants' clinical practice and their professional teams (Skourteli et al., 2023). Additionally, several short OD workshops of 2, 3, or 4 days have been conducted in various places [Training Course at Yale University | Institute For Dialogic Practice, 2022; Brown, 2023; Dialogue (R)Evolution, 2022], but research on these workshops is relatively scarce compared to that on foundation or full trainings.

In many relevant studies, service providers who participated in an introductory short workshop/training and pilot implementation to introduce OD for the first time indicated that an approach grounded in OD principles required change on many levels, including their professional identity, teamwork within the organization, and collaboration with other sectors; they often mentioned the difficulty of applicability due to the differences between OD practices and traditional services.

Thus, to properly plan the introduction of OD for the first time in a country or system, an introductory phase prior to formal training and implementation requires careful design to minimize conflicts with existing services and subsequent resistance, maximize the experience of the unique strengths of OD training, and ensure

that all participants are motivated to change their own clinical practice and organization.

1.2 Introduction of OD as part of the WHO QualityRights Project in South Korea

In South Korea, a lack of legislation and practice guidelines to encourage collaboration between multi-disciplinary services results in a highly fragmented system of service providers, and user involvement in the system has been weak (National Mental Health Center of Korea, 2023). Community crisis interventions have been heavily focused on rapid, involuntary hospitalization, leading to high rates of burnout and resignation among mental health workers (Yoon, 2023). The National Human Rights Commission of Korea (NHRCK) reported that human rights protection in the mental health sector in South Korea is weak on several fronts and suggested that the right to self-determination, the provision of options other than hospitalization, and the reduction of coercive treatment are urgently needed (National Human Rights Commission of Korea, 2021).

We can assume that both service users and providers face challenges in South Korea's current system. To overcome this situation, there is a need for new collaboration and dialogue among all stakeholders. The WHO guidelines—which synthesize human rights- and recovery-based approaches proposed in various fields and promote multi-stakeholder, multi-sectoral collaboration—have been suggested as a useful framework for service reform (Cho, 2023).

In 2021, the Ministry of Health and Welfare called for an R&D project to develop training and implementation guidelines for the dissemination of WHO QualityRights-based services in the South Korean context, with requirements to include OD. As part of this project, the first OD introductory workshop in Korea and a subsequent year-long pilot implementation took place. Details of the organization and implementation of the project as a whole and the state of mental health services in Korea in relation to this are described in Supplementary material.

1.3 Study objectives

The primary research questions for this study are as follows: (1) *What were the participants' experiences of attending the 5-day OD introductory workshop?* (2) *What were the participants' experiences of 1-year OD pilot practice?* (3) *How did participants' opinions about OD change over the course of 1 year of the OD pilot practice following the workshop as part of the WHO QualityRights Project?*

By addressing these questions, we aimed to gain insights that could provide a basis for designing training and service guidelines to meet the needs of the South Korean mental health system in implementing OD, and also to clarify how OD should reach stakeholders in the field.

The case in this study is unique in that OD was not introduced in isolation but as part of a multi-component service package based on the WHO guidelines. An extended question is therefore to explore the impact of embedding OD within a new human rights-based framework.

2 Methods

2.1 Study contexts

The R&D projects mentioned above aim to develop OD and non-coercive treatments, supported decision-making, and recovery programs in parallel, and this research focused on the development of OD implementation guidelines and was conducted in the following phases.

2.1.1 Introductory workshop

In March 2023, two international trainers from Finland and the United Kingdom were invited to conduct an introductory workshop for five consecutive days (40 h in total). A total of 28 participants from collaborating organizations participated, including psychiatrists, nurses, social workers, clinical psychologists, peer supporters, family members, and an anthropologist.

The workshop incorporated theories on the seven core principles and 12 key elements of OD, small-group exercises to practice techniques, role-play, and discussions on how to introduce OD.

2.1.2 One-year pilot network meetings

Pilot network meetings have been held on a community basis in Suwon City, the catchment area, since October 2022. During the referral process, a community mental health center promoted the pilot, and an individual or family member called the center and was connected with a team of two to four facilitators for a meeting at their preferred location (most often their home). Clients with suspected or confirmed psychotic symptoms were eligible.

Over the course of the study, 89 network meetings were held with 11 families, with all meetings lasting at least 90 min. The team of facilitators included a Korean psychiatrist (SK) who had completed 1 year of formal OD foundation training and was undergoing international trainer's training in the UK during this period. He attended almost all the sessions to promote fidelity to the key OD elements.

2.1.3 Supervision

Consent was obtained from the pilot clients. Using the video recordings, the researcher (SK) visited London to receive group supervision from international OD trainers. Supervision feedback was shared with colleagues in South Korea.

Monthly supervision meetings were held separately, to which all workshop participants were invited. Further, the project researchers met weekly, during which supervision of the pilot occurred on an *ad-hoc* basis. All meetings were facilitated by the same researcher (SK).

2.2 Participants

We selected participants through purposive sampling during an introductory OD workshop in South Korea. A total of 28 people attended the workshops. Of these, 25 consented to participate in the study and completed the first survey. In the second round, 24 of the 25 surveys were returned.

At the end of the pilot year, we categorized this group into those who had experienced network meetings for pilot practice and those who had not.

*Network meeting experienced group: Ten people in total who participated in network meetings during the pilot as co-facilitators with a specific researcher (SK) who had undergone formal foundation training and trainer's training.

*Network meeting inexperienced group: The remaining group of participants, excluding the above group.

2.3 Materials

Participants were provided with a questionnaire booklet that included items to collect demographic data such as gender, age, occupation, and experience with mental health services.

To assess the participants' views of OD and their experiences with the OD workshop and pilot practice, we created an Open Dialogue Opinion Questionnaire based on the questionnaire developed by Razzaque and Wood (2015). The first survey was administered 1 week after the workshop, and the second survey was conducted 1 year later.

The questionnaire was divided into two sections, including qualitative and quantitative elements: one with Likert-type questions and the other with open-ended questions. The Likert-type questions asked participants to rate the seven core principles of OD, as follows (Seikkula et al., 2001, 2003): (1) the provision of immediate help; (2) a social network perspective; (3) flexibility and mobility; (4) responsibility; (5) psychological continuity; (6) tolerance of uncertainty; and (7) dialogism.

For each core principle, participants were asked two Likert-type questions: "To what extent do you agree that each core principle is important in caring for the person?" and "To what extent do you agree that these principles are currently applicable in mental health services in South Korea?" Participants were asked to rate their responses on a 10-point Likert scale ranging from 0 (*strongly disagree*) to 9 (*strongly agree*). Additionally, only in the second questionnaire, participants were asked the following: "How much of each principle do you think you can immediately apply to your workplace?" They were asked to respond using the same Likert-type scale, ranging from 0 (*not currently applicable*) to 9 (*currently applicable*).

Four open-ended questions were asked to obtain participants' qualitative feedback on OD:

- What do you think is important about Open Dialogue?
- What are your opinions about Open Dialogue?
- What challenges do you anticipate in implementing Open Dialogue? (first survey); What challenges have you experienced in implementing Open Dialogue? (second survey)
- How would you explain Open Dialogue to someone who is unfamiliar with it?

Participants were asked two additional questions in the first survey: "What did you like about the Open Dialogue introductory workshop?" and "What did you dislike about the Open Dialogue introductory workshop?" and one additional question only in the second survey: "What support or resources do you think you need to implement and sustain the core principles of Open Dialogue that you rated as highly applicable right now in your workplace?"

2.4 Data collection

Participants were informed that the two questionnaires would be sent to their email addresses on the last day of the workshop. Before providing the two questionnaires, participants completed a demographic form and signed a consent form. The first survey was sent after the workshop in March 2023 and collected within 1 month, and the second was sent 1 year later and collected over a month. If the response to an open-ended question was unclear, the first author (SC) contacted the participant via email or text message for clarification to ensure accurate representation.

2.5 Ethical considerations

This study was approved by the Institutional Review Board of Ajou University Hospital (AJOUIRB-SB-2023-173). Participants gave written informed consent, were informed about the voluntary nature of their participation, and could withdraw at any time without consequences. The research adhered to national laws and institutional regulations. Data were protected, ensuring anonymity and minimal demographic collection, and stored securely on a password-protected laptop.

2.6 Analysis

2.6.1 Variables and statistical analysis

We tested the normality of the survey data using the Shapiro–Wilk test. Student's *t*-test compared age and career length data between groups practicing and not practicing network meetings, while the chi-square test compared other demographic data. For Likert data, we analyzed the mean and standard deviation of scores for the importance and availability of the seven key principles of OD at both time points ($n = 24$). To assess the statistical significance of changes in scores over time for all participants, we conducted paired *t*-tests. Additionally, to evaluate whether the changes in scores over time differed between the group that had experience with network meetings ($n = 10$) and the group that had no experience with network meetings ($n = 14$), we performed a mixed ANOVA to test for interaction effects between time and group experience. Analyses were performed using SPSS version 25.0

2.6.2 Thematic analysis

Data analysis followed (Braun and Clarke, 2006) six-step thematic analysis method. Two authors (SC & SK) immersed themselves in the data, reviewing participants' responses to open-ended questions to identify key semantic units. They independently coded the data, then refined the codes collaboratively, resulting in 750 codes. SC categorized themes by clustering similar codes and delineating overarching narratives, which were reviewed and refined for coherence and relevance. A multi-author validation process involving YHC, a psychiatrist working in a community mental health center, and SKJ, a psychiatrist in hospital services, both of whom participated in the OD introductory workshop, was then undertaken to define and name the themes. This approach provided a more practice-relevant perspective on the data and ensured that the findings accurately reflected real-world contexts. Through consensus and discussion, themes were selected to best encapsulate participants' perspectives, enriched by input from multiple authors. Four main themes and ten subthemes emerged from the analytical process.

3 Results

3.1 Demographic characteristics

Twenty-four participants completed both the first and second surveys. We included a wide range of people, including psychiatrists, nurses, social workers, clinical psychologists, art therapists, peer supporters, and family activists. We distinguished between those working in hospital settings within the national health insurance system and those working in community organizations funded by the public health budget. The demographic characteristics of all participants are shown in Table 1, and the characteristics of the two groups according to whether they practiced network meetings are shown in Supplementary Table 1.

3.2 OD likert-type scale

A Paired t-test was conducted to evaluate whether there were statistically significant differences over time in the perceptions of the overall participants regarding the importance and availability of the seven key principles of OD at two time points (t1 and t2) (Table 2). Immediately after the workshop (t1), the mean importance scores for all principles were above 7.71, with dialogism scoring the highest at 8.50. Although availability also scored highest in dialogism, the average was 6.83, and all mean values were observed to be lower compared to their importance scores. One year later (t2), while there was a trend of decreased mean values in importance across all principles, these changes were not statistically significant. In terms of availability, a decline was also observed compared to t1, with flexibility and mobility showing a statistically significant decrease from a mean of 5.79–4.79 ($p = 0.044$).

In the subgroup analysis, participants were divided based on their engagement in network meetings. A mixed ANOVA assessed interaction effects between time (t1 to t2) and group experience, focusing on differences arising from network meeting involvement (Table 3). For importance, both the group that practiced network meetings and the group that did not exhibited similar trends in mean value changes from t1 to t2, with no statistically significant differences. For importance, both the group that practiced network meetings and the group that did not exhibited similar trends in mean value changes from t1 to t2. However, there were no statistically significant differences in the main effect of group (practices NM vs. non-practiced NM), the main effect of time (t1 vs. t2), or the interaction effect between group and time. Conversely, for availability, while there were no significant main effects for group or time on tolerance of uncertainty, a statistically significant interaction effect between group and time was found ($p = 0.04$).

3.3 Qualitative results

Four main themes and ten subthemes emerged (Table 4). The main themes and subthemes are summarized below, including representative quotes.

3.3.1 Main Theme 1. Uncomfortable ambivalence toward OD: systemic, cultural, and professional challenges in Korea vs. human rights potentials

Main Theme 1 illustrates the participants' uncomfortable ambivalence when they first encountered OD in the introductory workshop because it differed from the traditional model. Initially, participants were reluctant and doubtful about implementing OD, perceiving it as challenging to apply in Korea and unsuitable for the Korean context. Despite these reservations, they recognized the need for OD to restore human rights. As workshop participants, they felt the weighty responsibility to gain relevant skills and implement OD in their practice. The subthemes included "Reluctance and Doubt about a Different Approach" and "The Weighty Responsibility of OD Implementation as a Human Rights Potential."

3.3.1.1 Subtheme 1: Reluctance and doubt about a different approach to traditional practice

Subtheme 1 highlights the reluctance and doubt workshop participants felt about implementing OD domestically, focusing on systemic, cultural, and professional challenges. On the first day of the workshop, participants were introduced to OD's core principles. Many unfamiliar with OD found it markedly different from existing practices, expressing significant concerns about its feasibility in Korea with phrases such as "doubtful," "uncomfortable," and "quite challenging" were common (P8, 10, 11, 13, 17, 18, 19, 21).

- *Systemic challenges*

Participants identified several systemic challenges to applying OD in Korea, due to differences between the Finnish and Korean healthcare systems (P2, 6, 15, 20, 22). Korea's national health insurance system operates on a fee-for-service basis, and participants questioned the feasibility of integrating OD into this model (P20). Concerns included the lack of specific billing codes for OD (P6, 15, 20), potential funding difficulties (P20), and the risk of OD becoming an exclusive, high-cost treatment (P17, 22).

TABLE 1 Demographic characteristics of participants.

Demographic			*N*	%	Mean	S.D.
Age (yr)			24		47.88	10.67
Gender	Male		5	20.8		
	Female		19	79.2		
Occupation	Medical	Psychiatrist	3	12.5		
		Nurse	11	45.8		
	Non-medical	Social worker	4	16.7		
		Psychologist	1	4.2		
		Art therapist	1	4.2		
		Peer support	2	8.3		
		Family activist	2	8.3		
Length of career (yr)			24		16.18	7.31

Additionally, the lack of Korean policies and clinical guidelines supporting OD services was seen as a significant barrier (P9, 13, 24). The fragmented nature of Korea's mental health service delivery system and the absence of guidelines for collaboration between psychiatric hospitals and community services hinder the implementation of OD principles such as "responsibility" and "psychological continuity" (P2, 3, 6, 17, 24).

Participants also highlighted issues related to understaffing and excessive workloads (P1, 2, 3, 5, 6, 7, 10, 11, 14, 16, 17, 19, 20, 21, 22, 25). Frequent job changes and high turnover make it difficult to maintain psychological continuity (P6, 7, 15). Implementing OD while maintaining existing services was seen as difficult due to insufficient numbers of mental health professionals (P11, 21, 25). One participant noted that a single professional in a community mental health center manages over 50–60 clients, in addition to other mandatory tasks (P21). Another highlighted that one psychiatrist in a psychiatric hospital has 60–70 inpatients (P22). Managers expressed reluctance to propose OD because their teams are understaffed and overworked, fearing resentment from staff and pressure from government performance requirements (P8, 12, 16).

- *Cultural challenges*

Participants expressed concern that cultural factors in Korea would hinder the application of OD (P3, 4, 7, 8, 12, 16, 20, 22). Specifically, Korea's "*Pali-Pali (hurry-hurry)*" culture contrasts with OD's principles of tolerating uncertainty (P7, 8, 20, 22). This cultural tendency, driven by a sense of urgency, has facilitated rapid economic growth but reflects discomfort with uncertainty (Park, 2019). One participant noted that the *"Pali-Pali"* culture leads service users and families to seek quick solutions, making it challenging to tolerate uncertainty in immediate medical care (P8, 20, 22). They also anticipated related challenges within Korea's rapid healthcare system, where patients can easily access immediate appointments with psychiatrists and receive prescriptions (P20, 22).

Additionally, there was concern that dialogism would be difficult to adopt in a culture where "evaluation and judgment are familiar and silence is considered a virtue" (P2, 3). The emphasis on silence in Korean culture (Robertson, 2019), stemming from "*Nunchi*"—the practice of reading others' feelings and adapting behavior to maintain harmony—contrasts with dialogism.

- *Anxiety of new professional roles*

Participants were unfamiliar with the professional roles required in OD and worried that it would take a long time for professionals, clients, and networks to understand and trust OD (P2, 11, 18, 16). They expressed concern about getting clients and networks, especially those in crisis, to understand OD's philosophy, as these individuals often expect quick symptom relief, typically through medication (P2).

While participants were theoretically aware that OD requires professionals to have the courage to embrace new approaches (P2), they found it challenging to let go of the conventional tendency to solve problems (P18). They felt ambivalent about adopting new roles, for "fear of feeling stuck and suffering from low self-esteem" (P17). They found it challenging to implement dialogical attitudes, such as "changing their language," "being non-judgmental," and "tolerating uncertainty" (P2, 3, 16).

Participants felt uncomfortable stepping out of their assigned roles within the expert-centered system, with one family activist (P4) expressing fear about facilitating network meetings due to a lack of medical knowledge. Another participant (P9), a peer supporter, doubted her suitability as a facilitator due to a perceived lack of expertise. While one psychiatrist (P13) argued for the active involvement of psychiatrists for comprehensive understanding of clients, another family activist (P3) felt that the absence of a psychiatrist would be limiting.

3.3.1.2 Subtheme 2: The weighty responsibility of OD implementation as a human rights potential

Subtheme 2 describes the responsibility that workshop participants felt toward OD at the beginning of the workshop. Despite recognizing the significant challenges of applying OD in the Korean context, participants understood the potential and necessity of OD to complement conventional mental health services that have human rights limitations.

TABLE 2 Results of a paired *T*-test for measures 1 month post-workshop (t1) and 1 year post-workshop (t2) for all participants.

Variable		Mean (±S.D.)	*t*	*p*
Importance				
Provision of immediate help	t1	7.71 ± 1.65	1.813	0.083
	t2	7.33 ± 1.97		
A social network perspective	t1	8.17 ± 1.07	2.076	0.050
	t2	7.39 ± 1.85		
Flexibility and mobility	t1	7.96 ± 0.95	0.768	0.450
	t2	7.71 ± 1.49		
Responsibility	t1	7.96 ± 0.86	1.440	0.163
	t2	7.50 ± 1.50		
Psychological continuity	t1	7.92 ± 0.97	1.551	0.135
	t2	7.50 ± 1.69		
Tolerance of uncertainty	t1	8.04 ± 1.40	1.440	0.163
	t2	7.58 ± 1.32		
Dialogism	t1	8.50 ± 0.98	0.440	0.664
	t2	8.42 ± 0.83		
Availability				
Provision of immediate help	t1	4.63 ± 2.04	0.000	1.000
	t2	4.63 ± 2.39		
A social network perspective	t1	5.92 ± 1.86	0.730	0.478
	t2	5.54 ± 1.82		
Flexibility and mobility	t1	5.79 ± 1.82	2.127*	0.044
	t2	4.79 ± 1.59		
Responsibility	t1	5.75 ± 1.70	0.720	0.479
	t2	5.50 ± 1.59		
Psychological continuity	t1	4.29 ± 2.16	−1.496	0.148
	t2	5.13 ± 2.21		
Tolerance of uncertainty	t1	5.17 ± 2.04	−0.920	0.367
	t2	5.54 ± 1.91		
Dialogism	t1	6.83 ± 1.88	0.207	0.838
	t2	6.75 ± 1.54		

NM, network meeting, $^{*}p < 0.05$.

This realization led to a strong, albeit burdensome, sense of responsibility for implementing OD, given its potential to enhance human rights.

- *Recognizing the limitations of conventional psychiatric services in South Korea*

While the human rights limitations of mental health services in South Korea were not directly discussed in the workshop, many participants described negative experiences with traditional services. The workshop prompted them to "reconsider the realities and limitations of the traditional medical model" (P11, 22).

Participants recounted the trauma of forced treatment, noting that hospitalization and medication were the default responses to crises (P16, 17, 24). This involuntary treatment led to lifelong psychological trauma (P13, 15, 24), left clients feeling stigmatized and anxious (P5), and caused family conflict and isolation (P1). Clients often lost their social roles and positions after involuntary admission (P6, 14).

The one-way communication typical of traditional psychiatric services was seen as exacerbating client isolation. Providers, "accustomed to authoritative and controlling interventions" (P13), would "systematize clients unilaterally" (P3), "hold therapy meetings exclusively among providers" (P5), and exclude clients from conversations (P5, 14). This approach led clients to become passive and resistant (P13), with "providers burdened by the increased responsibility due to dependence from clients" (P11, 21, 23).

TABLE 3 Results of a mixed ANOVA for measures taken at 1 month post-workshop (t1) and 1 year post-workshop (t2) for participants grouped by network meeting practice.

Variable		Group that practiced NM	Group that did not practice NM	*F*	*p*
		Mean (±S.D.)	Mean (±S.D.)		
Importance					
Provision of immediate help	t1	7.40 ± 1.35	7.93 ± 1.86	0.50	0.49
	t2	7.20 ± 1.99	7.43 ± 2.03		
A social network perspective	t1	8.44 ± 0.88	8.00 ± 1.18	0.06	0.81
	t2	7.78 ± 1.79	7.14 ± 1.92		
Flexibility and mobility	t1	7.90 ± 1.10	8.00 ± 0.88	0.41	0.53
	t2	7.90 ± 0.99	7.57 ± 1.79		
Responsibility	t1	7.80 ± 0.79	8.07 ± 0.92	1.51	0.23
	t2	7.80 ± 1.23	7.29 ± 1.68		
Psychological continuity	t1	7.80 ± 1.03	8.00 ± 0.96	0.003	0.96
	t2	7.40 ± 1.35	7.57 ± 1.95		
Tolerance of uncertainty	t1	8.20 ± 1.03	7.93 ± 1.64	0.90	0.35
	t2	8.10 ± 0.88	7.21 ± 1.48		
Dialogism	t1	8.80 ± 0.42	8.29 ± 1.20	0.01	0.94
	t2	8.70 ± 0.48	8.21 ± 0.97		
Availability					
Provision of immediate help	t1	4.80 ± 2.04	4.50 ± 2.10	2.47	0.13
	t2	3.80 ± 2.53	5.21 ± 2.19		
A social network perspective	t1	6.60 ± 1.35	5.43 ± 2.06	0.74	0.40
	t2	5.70 ± 1.70	5.43 ± 1.95		
Flexibility and mobility	t1	5.90 ± 1.73	5.71 ± 1.94	0.28	0.6
	t2	5.20 ± 1.23	4.50 ± 1.79		
Responsibility	t1	5.70 ± 1.49	5.79 ± 1.89	0.13	0.72
	t2	5.60 ± 1.43	5.43 ± 1.74		
Psychological continuity	t1	3.50 ± 2.12	4.86 ± 2.07	0.73	0.40
	t2	4.90 ± 2.28	5.29 ± 2.23		
Tolerance of uncertainty	t1	5.90 ± 1.66	4.64 ± 2.17	4.76	0.04*
	t2	5.30 ± 1.83	5.71 ± 2.02		
Dialogism	t1	7.30 ± 1.34	6.50 ± 2.18	0.20	0.66
	t2	7.00 ± 1.76	6.57 ± 1.40		

NM, network meeting, $^{*}p < 0.05$.
The values of F and p are the values of (group*time).

- *The potentials of OD for human rights restoration*

In contrast to traditional mental health services, participants found OD to be highly meaningful for realizing clients' human rights values (P5, 13, 14, 23, 25). OD was seen as restoring clients' human rights by giving them agency and control over their psychiatric treatment decisions and fostering mutual accountability (P6, 15, 17, 18, 22, 23, 24). OD was perceived as a "collaborative service" with clients rather than a monopoly of professionals (P13). By returning the initiative to clients, professionals hoped to alleviate their psychological burden and pressure, and to reduce the overwhelming sense of responsibility they felt in traditional mental health services (P5, 11, 13, 15, 20, 21, 24).

TABLE 4 Main themes and subthemes extracted from the thematic analysis.

Main theme	Sub theme	Content
Uncomfortable ambivalence toward OD: systemic, cultural, and professional challenges in korea vs. human rights potentials	Reluctance and doubt about a different approach to traditional practice	• Systemic challenges • Cultural challenges • Anxiety of new professional roles
	The weighty responsibility of OD implementation as a human rights potential	• Recognizing the limitations of conventional psychiatric services in South Korea • The potentials of OD for human rights restoration
From ambivalence to hope: creating safe spaces with experiential learning of OD in workshop	Gradual immersion in OD through exercises and role-plays	• Healing experiences of being heard and having responses • Recognizing the need for multiple perspectives through reflection exercises • Experiencing different roles and understanding each other
	Creating a safe space and solidarity	• Hierarchy dissolution and individual spontaneity unleashed • Internal ambivalence and diverse external perspectives evolve into polyphony • Building a sense of Solidarity
	Fueled with hope for implementing OD in practice	• Understanding OD as a way of life beyond a mere skill and discovering resources as a facilitator • Expecting OD implementation in various settings and attunement among services
Striving to implement OD as a human rights approach in various settings	Restoring dignity	• Attentive listening and respecting voices • Respecting pace and embracing uncertainty
	The role of Open Dialogue in supporting human rights	• Restoring autonomy and self-determination • Reducing coercion • Promoting collaboration within network and inclusion in community
Identifying challenges and exploring complements for OD implementation	Personal perspectives	• Confusion surrounding the comprehension of OD • Facilitator self-reflection • Maintaining connectivity and sustaining reflective supervision
	Organizational perspectives	• Difficulty in implementing in hierarchical institutional cultures • Creating a new institutional culture
	Policy and institutional perspectives	• Time commitment • Difficulty in ensuring psychological continuity • Safety and legal concerns in crisis intervention • Need for training programs • Policy and institutional support

3.3.2 Main Theme 2. From ambivalence to hope: creating safe spaces with experiential learning of OD in workshop

Main Theme 2 discusses how participants' initial ambivalence shifted to hope for OD practice through their experience in the OD workshop. Through experiential learning, participants realized that OD is not just a skill but an attitude and a way of life, discovering its practical possibilities. The creation of a safe space allowed participants to voice their internal ambivalence, leading to a natural coexistence of diverse internal and external perspectives. Strong emotional exchanges fostered a sense of solidarity, with participants looking forward to shaping the future of mental health services and implementing OD in their settings. The subthemes were "Gradual Immersion in OD through Exercises and Role-plays," "Creating a Safe Space and Solidarity," and "Fueled with Hope for Implementing OD in Practice."

3.3.2.1 Subtheme 1: Gradual immersion in OD through exercises and role-plays

Subtheme 1 describes how participants were immersed in OD through the workshop's exercises and role-plays. Many participants found these activities to be the most satisfying part of the OD workshop, feeling as though they were participating in real network meetings (P13, 23). One participant noted, "The exercises and role-plays made me realize the significance of OD, which was difficult to accept in theory" (P17).

- *Healing experiences of being heard and having responses*

Through these exercises and role-plays, participants had the opportunity to fully share their stories and receive responses, experiencing unconditional listening. Many reported this as a healing experience (P8, 9, 10, 16, 17, 18, 20). A psychiatrist noted, "There are very few opportunities for mental health professionals to share their deepest stories and experience empathy, and this workshop provided a healing experience in a safe space. This experience will help us listen to our clients' stories" (P20).

The following quote is a survey response from a participant who is a peer support worker. She found healing and satisfaction in expressing her deepest feelings during the workshop.

> When I went to the doctor... I didn't tell him about my difficulties because I was afraid, he would increase my medication... From the second day of the workshop, I was thinking a lot and crying, but I was able to talk about my feelings and get empathy and listen to other people's stories... I really liked the process. (P9)

- *Recognizing the need for multiple perspectives through reflection exercises*

Through reflection exercises, participants acknowledged the value of diverse perspectives in network meetings (P6, 8, 14, 15, 21, 22). They described "how reflection enabled them to hear various inner voices" (P22), "organize their thoughts" (P14), and "gain deeper insight into clients' experiences" (P6). One participant (P8) recognized "reflection as a powerful tool that could deepen understanding and bring unique energy to both clients and network members."

- *Experiencing different roles and understanding each other*

Workshop participants gained a deeper understanding of others by experiencing multiple roles in role-play. After playing the role of the person at the center of concern, one family activist shared, "I thought long and hard about the fact that I could be in the other person's shoes and that our souls are as clear and transparent as a crystal ball when we role-play and connect with each other" (P3). Mental health professionals (P21, 22) found role-plays beneficial in understanding their clients, whereas peer supporters (P9, 14) found it meaningful to play the role of a professional.

3.3.2.2 Subtheme 2: Creating a safe space and solidarity

Subtheme 2 addresses the creation of a safe space, which was crucial in transforming uncomfortable ambivalence into hope. Through experiential learning, participants learned to respect and listen to each other's voices, moving away from perceiving disagreements as requiring argument or persuasion. This process transformed internal ambivalence and external disagreement into polyphony, fostering a safe space where the active exchange of feelings and opinions evolved into a sense of solidarity.

- *Hierarchy dissolution and individual spontaneity unleashed*

Despite the short duration of the workshop, the participants experienced significant internal changes and established a safe space together. Initially, there was an imbalance of voices due to an invisible hierarchy among the participants. However, by the last day of the workshop, this hierarchy gradually dissolved, and "everyone felt comfortable engaging in dialogue regardless of rank or status" (P16). Once a safe space was established, "dialogue became more active, and participants' spontaneity emerged" (P24). The following quote is a participant's response that illustrates the change process of incrementally breaking down hierarchies and creating safe spaces:

> The youngest participant, who had no clinical experience in psychiatry, became increasingly relaxed, open, and did not care about *Nunchi* as the day progressed. It was touching to see how enthusiastically the other participants responded to her. (P2)

- *Internal ambivalence and diverse external perspectives evolve into polyphony*

Once a safe space was created, participants began to freely share their diverse views and perspectives. Their inner ambivalence became an opportunity to "recognize their own desires" (P19) and change their thinking (P6). Participants' voices were no longer about persuasion but about enriching the discussion by engaging with professionals from different organizations, service users, and families (P2, 6, 11, 12, 17, 21, 22). The following quotes illustrate how the voices of different participants created an external and internal polyphony:

> It was true polyphony, and I especially appreciated hearing the skeptical perspective on OD during the discussions. Some people asked questions I had been thinking about and shared concerns I hadn't even considered. Before the workshop, my mind was confused and complicated, but after the workshop, I felt a sense of clarity (P22).

- *Building a sense of solidarity*

The experience of freely exchanging opinions and feelings in a safe space created a bond between participants (P20) and allowed them to comfort and support each other (P13, 21, 23). One participant reflected on the phrase "people are hope" (P16) and felt they had found "colleagues to share a new paradigm with" (P19, 22). Despite anticipating challenges in securing and practicing OD values in Korea, participants pledged solidarity by remembering the "value of togetherness" (P16) and committing to "trust in the power of the group and process" (P2).

3.3.2.3 Subtheme 3: Fueled with hope for implementing OD in practice

Subtheme 3 captures participants actively planning how they will practice OD after the workshop. On the last day, participants dedicated time to future planning. One participant noted the activeness and proactivity during this process (P24). Participants reflected on their roles as OD facilitators and the value of OD. They returned to their workplaces with concrete plans for OD practice, looking forward to future exchanges and collaborations with workshop resources.

- *Understanding OD as a way of life beyond a mere skill and discovering resources as a facilitator*

Initially, participants saw OD as an ideal technique for advancing clients' human rights and felt burdened by the obligation to implement it perfectly. After the workshop, however, they understood OD as a way of life, not just a technique.

The workshops allowed participants to examine their attitudes toward clients and their own lives (P1, 2, 6, 7, 8, 10, 12, 15, 16, 25). They realized that "judging and evaluating others was not conducive to recovery" (P15) and that simply listening could be very helpful (P1, 25). Participants questioned whether they were having authentic dialogue with themselves and others (P8) and were reminded of their own life philosophies and values (P12). They came to see OD as something "more profound than just a therapeutic technique" (P22).

- *Expecting OD implementation in various settings and attunement among services*

The workshop process gave participants hope that OD could be applied in Korea (P9, 16). After the workshop, they considered how to implement OD in their workplaces (P2, 4, 8, 11, 16, 17, 24). Participants found it meaningful to gather staff from hospitals and community mental health centers in one space; they expected that OD would be implemented, especially given the focus on person-centered services, with the hope that hospitals and community centers participating in the workshop would collaborate more effectively, even under a fragmented system (P2, 22, 24).

3.3.3 Main Theme 3. Striving to implement OD as a human rights approach in various settings

Main theme 3 reflects the workshop participants' efforts to implement OD in their workplaces. Participants practiced OD in various ways. Ten participants were involved in the network meetings as part of a team of facilitators (P2, 7, 8, 12, 15, 17, 19, 20, 22, 24), as categorized as Network meeting experienced group. Network meeting inexperienced group's participants also tried a dialogical approach at their workplaces by organizing meetings of clients, family members, and professionals gathered in a psychiatric unit (P2, 7, 15, 19, 20, 22), a day hospital (P5, 25), a community mental health center (P1, 12), a suicide prevention center (P18, 21). They applied some principles and elements of OD into their interactions with clients (P1, 3, 6, 7, 15, 18) and used these to self-help groups of service users' organizations (P3, 14). All of them were invited to monthly supervision to share OD practices. Two subthemes emerged: "Restoring Dignity" and "Discovering OD as a Support for Human Rights."

3.3.3.1 Subtheme 1: Restoring dignity

This subtheme describes how participants used careful listening and patience to move at the client's pace and ultimately work to restore the client's dignity. From their experiences in a variety of settings, participants recognized their importance in OD practice of respecting the client's voice and valuing their journey.

- *Attentive listening and respecting voices*

Participants recognized the importance of "fully listening to the client's painful experiences and supporting them in choosing their own path" (P2). They viewed listening to a person's life as a core value of OD (P2, 3, 10) and believed that engaging with the suppressed voice unfiltered (P3) through OD would help clients feel respected (P5, 18).

Focusing on one individual's story for an extended period was a challenge for facilitators (P8, 15, 17). However, they acknowledged the power of authentic listening to drive dialogue. For example, one participant (P2) recalled listening to a client who took more than 10 min to say a single sentence, and eventually witnessing the client feel comforted and open up (P19). And "respecting the voices of all participants in network meetings was seen as crucial for healing" (P15).

Other participants also practiced attentive listening in their own settings. One participant (P7) working in a closed ward described how her initial negative reaction to a client who was self-harming changed after the treatment team used a dialogic approach in which they listened to the client together. Professionals in a day hospital (P5, 25) organized meetings of families and clients in crisis of considering hospitalization and to listen to their struggles and difficulties.

A family activist (P3) changed the way multifamily self-help groups held meetings to a dialogue style, believing that the experience of listening and being listened to would be effective in recovery. A peer supporter (P14) stated that when she facilitates a self-help group, she tries to "honor a variety of voices, including those of the more psychotic, rather than confronting or excluding them."

- *Respecting pace and embracing uncertainty*

Participants recognized that respecting the client's pace and embracing uncertainty are core values of OD. However, pacing was challenging, especially when families had difficulty accepting uncertainty (P19). Families often prioritized solutions over conversation and demanded quick decisions from professionals (P2, 22). Participants empathized with families' impatience and frustration because "they were used to being the answer-givers" (P5). One participant described experiencing "mental burnout from slow change" and wondered in her mind if hospitalization would be a quicker solution (P19).

Gradually, the participants became more comfortable with uncertainty, as did the clients and their families (P17). They found that "the most impressive part of OD is that time moves around the person" (P17) and realized that change requires waiting and that "time has to build up" (P15, 17, 22).

A hospital social worker initially believed that perfect planning and implementation were necessary for change, but she became more accepting of client diversity after practicing the principle of tolerance of uncertainty (P6). A participant from a suicide prevention center (P18) described how waiting for a client's silence led to a trusting relationship: "For a client who was difficult to interview because he was almost nonverbal due to his symptoms, I said, 'It's okay if you don't say anything right now, you can just be with me for this time,' and I wasn't afraid to wait for his silence. After that, I felt there was trust between us."

3.3.3.2 Subtheme 2: The role of Open Dialogue in supporting human rights

In subtheme 2, participants noted significant changes in clients and networks through "Attentive Listening and Respecting Voices" and "Respecting Pace and Embracing Uncertainty." They recognized that OD is a means to protect and facilitate human rights. OD enabled clients to exercise autonomy and self-determination, reducing coercive treatment. It also fostered community inclusion, helping clients find their place within the community. Participants saw OD as a significant example of human rights promotion through positive changes in clients and networks.

- *Restoring autonomy and self-determination*

In practicing OD, participants recognized that the professional's role is to respect and facilitate the client's right to self-determination

(P5, 7, 15, 20). In particular, they felt that "asking questions that give the client the freedom to choose the time, space, and people they want to meet with is the first key to ensuring their initiative and self-determination" (P14). In fact, they observed that clients and networks felt safer by choosing their own meeting place (P7).

Participants noticed that clients gradually became more self-directed with each session of the network meetings (P17, 22), and one client chose not to take psychiatric medication but continued to voluntarily attend the day hospital program (P2, 17, 19). Eventually, participants realized that "treatment plans that reflected the needs of the client and family reduced dropout" (P6).

Participants previously perceived clients as vulnerable and passive, with limited options (P4); however, during OD practice, participants came to recognize clients as independent beings (P3, 7) who could actively participate in and shape their own destinies (P15) and sought to build a dialogue to ensure that all services were agreed upon (P4).

Through the experience of clients and networks regaining autonomy and self-determination, participants realized that the OD approach is a "recovery system that helps clients and networks understand and choose what they want" (P4) and serves as "a pathway to bring a 'person-centered', 'service user perspective to clinical practice'" (P21).

- *Reducing coercion*

As participants practice OD in their settings, they have seen OD play an important role in reducing coercive interventions.

One participant attended several network meetings and has witnessed cases where the meetings alone have saved a crisis (P15). A situation that would have resulted in immediate hospitalization by the police in conventional mental health services was resolved through OD (P4). The following quote is a participant's description of a crisis that was resolved through a network meeting.

> One client had conflicts with the downstairs neighbor and even called the police, claiming there was the smell of a dead body from the upstairs apartment. Honestly, if they hadn't had the network meetings, I think it wouldn't have been long before they were forcibly hospitalized by the police... In the case of another client, he called his mother and said every night, 'It's really tough because people are stalking me. I'm worried I might hurt someone because of it.' However, almost a year has passed without any forced measures, and now he visits the outpatient clinic on his own and even attends the day hospital. (P15)

Witnessing these cases made it clear to many participants that OD is "a way of working that does not physically or psychologically harm clients in the way that traditional approaches do" (P13, 15, 17, 20, 21, 22, 24). In this sense, one participant defined OD as "a kind, gentle approach" (P2).

Participants in the "Network meeting inexperienced group" who did not participate as facilitators in the network meetings also practiced the values of OD in their workplaces and found it to be a more human rights-consistent approach for clients and families.

One participant (P12) from a community mental health center tried a different approach to intervening with clients in psychiatric emergencies. In South Korea, the Crisis Intervention Team and the police have traditionally conducted rapid emergency hospitalization together, but the participant tried a dialogical approach by bringing together the client's family, the police, social workers from the community center, and mental health professionals prior to hospitalization. As a result, the client voluntarily visited an outpatient clinic and decided to be admitted on his own, which the participant described as "a difficult process that took three times longer than usual, but as a result, I experienced a human rights-centered hospitalization process and became aware of my role as a professional."

Staff at a university day hospital (P5, 25) saw hospitalizations deferred after holding a family-client dialogue meeting and realized that "even a small amount of communication within the client's network could prevent a forced hospitalization" (P25). A nurse (P7) working in an acute psychiatric unit reported that they had previously used forceful injections and seclusion for patients with challenging behavior, but that they now attempted to have dialogue to understand the psychological factors underlying the patient's behavior before deciding on forceful measures.

The experiences described above resonated with the participants, as they had often witnessed in their work in the mental health field clients being coerced into treatment in crisis situations, resulting in lifelong psychological trauma (P15). For participants, OD was "an opportunity to give a voice to the disempowered" (P2) and "the best option to reduce forced hospitalization" (P20).

- *Promoting collaboration within network and inclusion in community*

As participants witnessed the increased collaboration and communication between clients and families, and inclusion within the community, through the OD approach, they came to see OD as "a safe and practical way" to help clients in crisis stay out of the hospital and live as contributing members of society (P2, 6).

Through their experiences of network meetings, participants realized that the process of network and client learning about each other's thoughts and perspectives through dialogue is an important factor in facilitating change (P9, 16), especially "when a large number of members come together to support and empathize with each other, which helps the client's recovery" (P15).

After the network meeting, families modeled the facilitator's conversational style, of listening to the client and understanding their grief, which facilitated communication within the families (P22). This resulted in a gradual change in the way family members treated the client and a change in their attitude toward each other to be more patient (P15). Families also began to take care of themselves, such as voluntarily attending psychiatric clinics to recognize and heal their own minds (P2).

These changes led to positive outcomes in terms of community inclusion, as clients who were reluctant to go outside began to visit art museums with their families (P15), some attended the day center consistently, some got jobs (P2), and some went back to school (P25).

3.3.4 Main Theme 4. Identifying challenges and exploring complements for OD implementation

As participants applied OD in their professional environments, they examined challenges at the personal, institutional, and policy

levels, seeking practical solutions. Participants focused on macro-level challenges when faced with OD, as described in Main Theme 1, the main theme 4 highlights participants' growing willingness to identify practical complements for domestic OD practice. This shift indicates that OD is moving beyond theory to concrete human rights practice. The subthemes were Personal, Organizational, and Policy Perspectives.

3.3.4.1 Subtheme 1: Personal perspectives

Subtheme 1 addresses the personal challenges and empowerment regarding practicing OD. Participants experienced confusion in understanding OD concepts and principles, especially in connecting the philosophy to their practice. To address this, they emphasized self-reflection, maintaining connections, and engaging in reflective supervision.

- *Confusion surrounding the comprehension of OD*

Participants felt confused about understanding and applying OD. They struggled with multiple internal concerns, such as the worry that OD might merely be a very gentle way to steer clients toward hospitalization and medication, which they wondered was contrary to OD's values (P2, 17). Communicating OD's meaning and practicing listening in peer support groups was also challenging (P3, 14). One participant expressed that OD, not being presented as a manualized theory, could be subjectively interpreted, which might cause confusion (P3).

- *Facilitator self-reflection*

To overcome confusion, participants emphasized the importance of self-reflection and mindfulness in their role as facilitators (P2, 8, 16).

- *Maintaining connectivity and sustaining reflective supervision*

Participants highlighted the importance of supervision in practicing OD (P2, 3, 6, 14, 15, 16). Ongoing supervision ensures the exchange of ideas and growth (P14, 15, 16), preventing network meetings from becoming "for-profit time-filling programs" (P2). Effective team chemistry is crucial, and regular meetings should foster relationships among team members (P6). Participants also emphasized the need to share and make sense of the confusion (P2, 3).

3.3.4.2 Subtheme 2: Organizational perspectives

Subtheme 2 presents the challenges and strengths of practicing OD from an institutional perspective.

- *Difficulty in implementing in hierarchical institutional cultures*

Participants found organizing network meetings within hierarchical healthcare organizations challenging. One participant (P22) explained that although her organization was founded on the principles of the therapeutic community, it was a hospital where the main goal was to relieve patients' symptoms; therefore, vertical communication was prioritized. The first meeting was organized in a top-down manner by a manager. As a result, expressing opinions on an equal footing while facilitating with her boss was challenging, impacting teamwork and hindering the ability to tolerate uncertainty during meetings (P2, 20). Suggestions for improvement were often disregarded. They also faced role confusion and resistance from service users and families to the new approach, which impacted the effectiveness of meetings (P2, 20, 22).

- *Creating a new institutional culture*

Several participants emphasized the need for a receptive and collaborative culture to successfully implement OD (P2, 5, 6, 18, 19, 22, 24). They highlighted "the importance of feeling connected to coworkers and growing together" (P18), "fostering an atmosphere that embraces a recovery perspective" (P22), and "striving to connect people with their communities" (P5).

3.3.4.3 Subtheme 3: Policy and institutional perspectives

Subtheme 3 describes the policy and institutional challenges participants faced in practicing OD and suggests solutions. Key issues included time commitment, ensuring psychological continuity within a fragmented mental health system, safety and legal issues in crisis intervention, training of professionals, and the need for institutional support.

- *Time commitment*

Participants worked extra hours to practice OD while maintaining their existing jobs, leading to increased overtime and psychological distress (P12, 15, 17, 18, 19, 20, 22, 25). Participants who took part in the network meeting highlighted the challenges of dedicating half of their workday to traveling to a client's home and facilitating the meeting (P2, 15, 19, 20, 22).

- *Difficulty in ensuring psychological continuity*

The fragmented mental health system in Korea makes it challenging to ensure psychological continuity in OD practice. For example, a network meeting was interrupted due to a lack of cooperation when a client was suddenly hospitalized (P22, 24). This highlighted "the need for a system that links patients from hospitalization to discharge" (P6, 25).

- *Safety and legal concerns in crisis intervention*

Participants expressed concerns about safety, liability, and lack of legal protection when applying OD in psychiatric emergencies (P1, 7, 20). There were questions about whether OD could be used effectively in suicide crises (P21) and the role of facilitators in emergencies (P14).

- *Need for training programs*

Many participants emphasized the need to train professionals to spread OD in Korea (P3, 4, 6, 7, 9, 15, 17, 19, 20, 22, 25). They mentioned the importance of an organization to operate and train people around OD, ensuring high-quality education and training (P4, 9, 20).

- *Policy and institutional support*

Participants stressed the need for institutional support and supply chains to enable OD access (P3, 7, 15, 19, 20, 21, 22, 24). They suggested policy support to embed training and supervision into basic work (P24), financial support and practice guidelines to promote a recovery perspective (P3, 20, 22, 24), and additional charges for staff (P7, 15). Qualitative evaluation methods, given OD's nature, and legal protection for facilitators in crisis situations were also recommended (P20, 21).

4 Discussion

The aim of this study is to explore the subjective experiences and opinions of participants involved in a 5-day OD introductory workshop and 1-year pilot practice as part of the WHO QualityRights Project in South Korea. According to the qualitative results, participants initially felt ambivalent toward OD due to systemic, cultural, and professional challenges in Korea, which led to reluctance and doubt. However, they also recognized its human rights potential and felt the weighty responsibility to implement OD (Main Theme 1). By the end of the workshop, their ambivalence had shifted to hope through experiential learning, fostering solidarity and optimism for future OD practice (Main Theme 2). After the workshop, participants implemented OD by restoring clients' dignity and autonomy, which reduced coercion and increased community inclusion (Main theme 3). They also identified and addressed personal, organizational, and policy challenges in practicing OD (Main theme 4). This study could provide foundational data for developing a formal training program and implementation guidelines for OD in the Korean mental health system.

The quantitative analysis employed two methods: a paired *t*-test for the entire participant group and a mixed ANOVA based on network meeting experience. The paired *t*-test revealed that, among the seven key principles, only "Flexibility and Mobility" in terms of availability showed a statistically significant decrease over time. This result may reflect the structure of mental health care system in South Korea, which is characterized by fragmentation and a provider-centered approach, limiting the flexibility required to meet the individual needs of clients. Furthermore, the finding could have been influenced by the fact that participants involved in network meetings reported feeling burdened by the time and effort required to travel to the client's home (Main Theme 4, Subtheme 3: Time Commitment).

Second, the mixed ANOVA results indicated a statistically significant decline in the availability of Tolerance of Uncertainty among participants who engaged in network meetings over the course of 1 year. Although tolerance of uncertainty is a key principle of OD, participants faced considerable challenges in sustaining it during network meetings (Main Theme 3, Subtheme 1). Factors such as rapid conclusions, traditional interventions, hypotheses, and assessment tools were found to obstruct the cultivation of tolerance for uncertainty and hinder the creation of a trustworthy therapeutic context or "scene" (Seikkula and Olson, 2003). The qualitative analysis suggests that participants were employed in institutions that predominantly relied on these conventional practices, which may have further complicated their efforts to maintain tolerance for uncertainty. This may explain the observed decline in its availability in the quantitative analysis. These findings align with prior research, which has highlighted similar difficulties faced by OD practitioners working within Treatment as Usual (TAU) environments when attempting to implement OD (Anestis et al., 2024). Fostering tolerance for uncertainty requires teamwork, and successful co-therapy necessitates creating space for both verbal and physical attunement (e.g., mindfulness) and for maintaining relationships (e.g., supervision) (Lagogianni et al., 2023). This is consistent with Main Theme 4, as identified by participants in this study.

Additionally, it is notable that "Dialogism" consistently scored the highest on both Likert-type scales assessing importance, availability, and immediate applicability, as measured in the survey at both points in time. The implications of this result will be discussed in the qualitative analysis that follows. This suggests that participants experienced OD, quite literally, through open dialogue at its core, both during the workshop and in the 1-year pilot practice.

In discussing the qualitative results, we will examine the implications across three key areas: training, practice, and team/policy dynamics.

4.1 Training

As with most studies examining the opinions and experiences of professionals in countries that first adopted OD, participants expressed reluctance and suspicion toward OD, citing numerous challenges to its initial adoption. The implementation of OD may "generate organizational, professional, and personal resistances," leading to significant challenges in its acceptance and adoption (Weber and Johansen, 2007; Søndergaard, 2010). In the UK, a survey of professionals before OD's introduction indicated resistance, considering OD in the NHS as a radical shift (Razzaque and Wood, 2015). Initial impressions of OD have been described as fearful and threatening, with concerns about changing professional roles (Razzaque and Wood, 2015), anxiety over incompetence and criticism in Greece (Skourteli et al., 2023), and ongoing resistance management at clinical and organizational levels in Australian private hospitals (Lennon et al., 2023).

A novel finding of this study is the ambivalence, not just resistance, professionals feel toward OD. Similar ambivalence was noted in Australian private healthcare, where professionals were both optimistic and skeptical during OD training and implementation (Dawson et al., 2021).

Ambivalence, as defined by attitudinal ambivalence, involves conflicting positive and negative feelings about the same object, prompting efforts to resolve these conflicts (Jonas and Ziegler, 2007). This state of ambivalence is perceived as highly uncomfortable, leading individuals to actively seek ways to resolve the conflict between incompatible evaluations (Newby-Clark et al., 2002). Addressing ambivalence is crucial when introducing or training for OD. Specifically, applying the key factors identified in this study that influence the transformation from ambivalence to hope in the training process may assist future trainees in managing

their ambivalence more effectively when planning and facilitating future OD trainings.

This study highlights that the weighty responsibility felt by participants is a crucial factor that needs to be addressed to facilitate OD training. Participants viewed OD as an ideal method for advancing clients' human rights but felt burdened by the obligation to implement it flawlessly. Stockmann et al. (2019) reported that some OD trainees in the multi-center ODDESSI trial found it challenging to practice OD within "a system prioritizing a technical approach." This suggests that treating OD as a skill to be perfected can be burdensome.

From a psychodynamic understanding of mental illness, the power imbalance between service providers and users is often explained by unconscious processes that lead to a role-assignment in which the professional assumes a "only healthy, knowledgeable, kind, powerful, and active" position and the patient assumes a "only ill, suffering, ignorant, passive, obedient, and grateful" position (Hinshelwood, 2004, p. 14). Since the not-knowing stance emphasized in OD contradicts this, professionals who need to be perceived as knowledgeable may struggle to accept "the courage to be vulnerable" (Lorenz-Artz et al., 2023) during the OD process, or they might feel overwhelmed, treating OD like a new psychotherapy technique to be mastered.

The findings suggest that it is important to facilitate the experience of OD as a way of life rather than a method to be practiced during training. The debate on whether OD should be viewed as "psychotherapy" or "a way of life" has been ongoing (Ong et al., 2019). Seikkula (2011) describes dialogism as a "way of life" learned through communication from birth. Simply listening, responding, and exchanging responses—elements that are already embodied from early childhood experiences—can be healing. It can be hypothesized that participants re-experiencing these fundamental elements during the workshop helped them embrace OD as a way of life, giving them confidence in their practice.

We identified two factors crucial for transforming ambivalence and weighty responsibility into hope: the content of the training and the organization of the training course.

4.1.1 Training content

Although this study involved a short, 5-day workshop, the results were consistent with participants' experiences in longer training courses in several aspects. Participants in a 3-year training course experienced unexpected healing, reporting changes in the co-production of meaning, language, and relationships due to a climate of trust (Runciman, 2021). In a 1-year foundation training, participants felt responded to and listened to through exercises and role-plays, gaining insights into the emotions of clients and network members in crisis (Aderhold and Hohn, 2021; Hendry et al., 2021). Similarly, a 4-day introductory training showed that participants adapted to dialogical practice and experienced inner knowing (Thorley et al., 2023).

Therefore, the findings of this study suggest that improving the potential impact of short-term OD workshops require placing less emphasis on the introduction of OD principles or theories, and more on experiential learning and "bodily knowing of OD" (Shotter, 2007) about OD as a way of life and the nature of processes. Through experiential learning, participants gradually became accustomed to dialogical practice, no longer perceiving initial ambivalence as something to be dealt with. They were able to exist in polyphony rather than seeing differing opinions as needing persuasion or unification. While not confirmed in this study, it is possible that this was achieved by the trainer creating a safe dialogical space for different voices and encouraging polyphony. Although the participants did not mention specifically trainers' intervention, this could indicate that trainers very naturally facilitated a dialogical culture by participating as containers within the dialogical space (Thorley et al., 2023). This gentle process may have made participants feel as though they were learning autonomously.

Additionally, organizing the training to prioritize experiential learning over merely explaining OD principles helps participants understand OD as a way of life. A qualitative study found that participating in a network meeting was the most authentic way to grasp OD, rather than first explaining its principles (Lorenz-Artz et al., 2023).

4.1.2 Strengths of mixed participant populations

In this study, the workshops brought together professionals, peer supporters, and family members from various community organizations and healthcare facilities in the catchment area where OD was being introduced. This mixed-group trainee structure was adapted from the QualityRights training tool (World Health Organization, 2019), which encourages mixed groups with participants from different backgrounds (professionals, service users). The mixed-group structure mirrors that of OD's network meetings. Participants in this study felt a sense of solidarity and hope through the workshops, a finding confirmed in other studies. In a 3-year OD training course in the UK, the training group itself practiced interactive ways of accepting differences of opinion, tolerating difficult emotions, and overcoming internal tensions during discussions (Wates et al., 2022). In an OD training in Australia, participants felt a strong sense of connection among themselves and learned by joining others (Buus et al., 2022). In a POD training, participants felt an emotional connection with people (Stockmann et al., 2019).

Thus, when planning and organizing short term OD training, it can be suggested that including professionals, peer supporters, and family members from local organizations and healthcare facilities in the catchment area where OD is to be introduced can foster a sense of solidarity and hope for future OD practice.

Moreover, the word "hope" appears several times in the participants' reports. This finding can be explained by the suggestion that hope is a shared practice rather than a personal sentiment and that it operates as a kind of language (Cuffari et al., 2022).

Figure 1 illustrates the process of the change from participants' initial ambivalence to hope and solidarity for OD practice during the introductory workshop. Initially, the ambivalence did not manifest as conflict or argumentation but rather transformed into solidarity and hope. This change can be attributed to the qualitative impact of experiential learning, the content of the training, and the strength of the mixed group. The collective hope and solidarity fostered by OD motivated participants to embrace a new approach throughout the year.

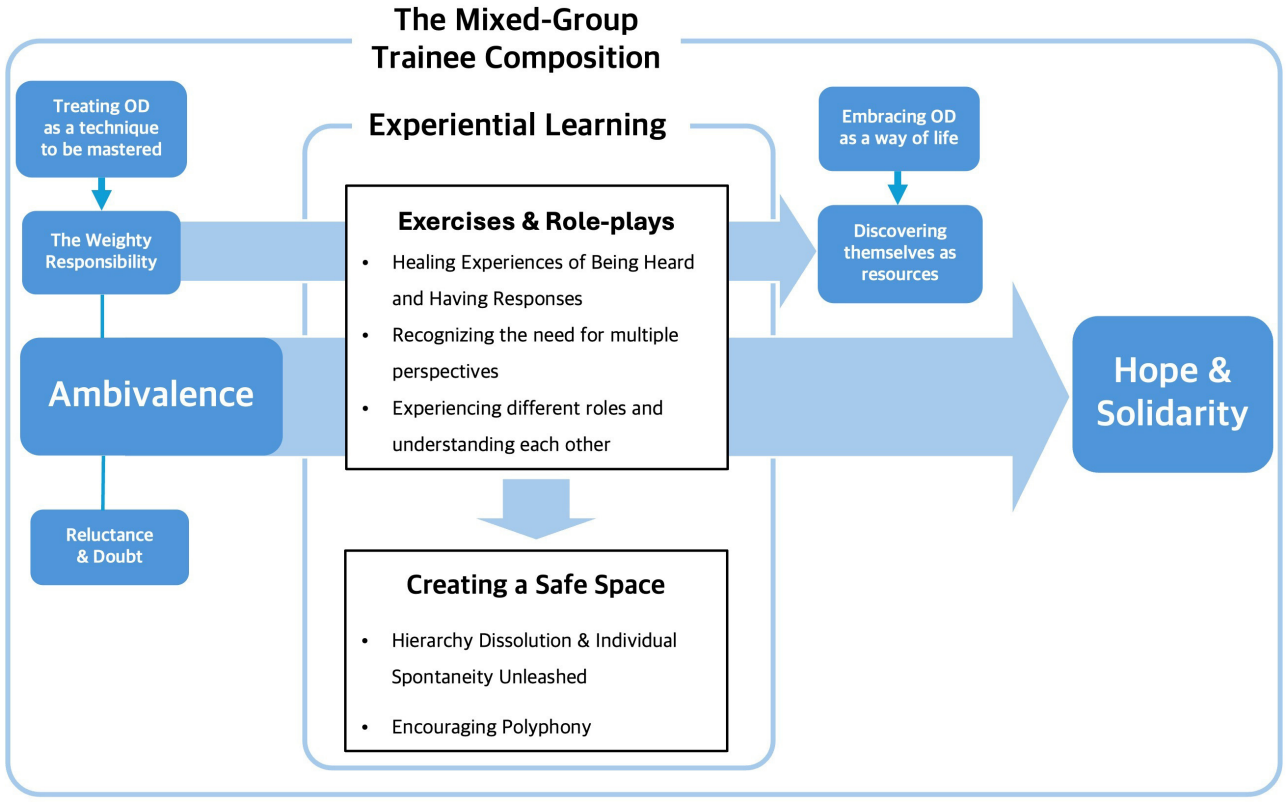

FIGURE 1
The process of change from ambivalence to hope and solidarity during the OD workshop.

4.2 Practice: OD as a human rights-aligned approach

Adopting a human rights perspective was useful in formulating the meaning-making of Main Theme 3. Despite human rights being a global concern in the context of mental health, little research has explored the direct relevance of OD to human rights principles. It has been suggested that OD should be considered a human rights-aligned approach, as many elements of the CRPD that underpin QualityRights are consistent with the fundamental principles of OD (Von Peter et al., 2019), and the WHO's guidance outlines the value of OD from a human rights perspective (WHO, 2021). Therefore, the findings reported in this article suggest that the practice of OD can contribute to securing the human rights of clients and networks.

Initially, participants in this study strived to honor the voices and respect the pace of their clients and network members through attentive listening. As a result, they facilitated self-determination and autonomy. The study results underscore that OD practice aligns with the principles of the CRPD, specifically Article 21, which asserts the right to freedom of expression and opinion, and Article 3, which emphasizes respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons. Clients' experiences of regaining dignity, autonomy, and self-determination through OD have been documented in several studies and are consistent with the findings of this study. For instance, Sidis et al. (2020) reported that young clients felt empowered to say what they wanted during network meetings. Similarly, clients who experienced OD in the UK valued the experience of having a choice and voice, being involved in treatment planning, and discussing their mental health needs above all other themes (Suntharajah et al., 2022). Additionally, the WHO suggests OD as a model of supported decision-making that respects the will of mental health service users (World Health Organization, 2019, p. 28).

Moreover, Von Peter et al. (2019) suggested that future research should examine how OD affects different forms of coercion. Encouragingly, our study found that OD can indeed prevent various forms of coercion. This is compatible with CRPD's the Article 14: Liberty and Security of Person, ensuring that persons with disabilities are not deprived of their liberty unlawfully or arbitrarily; Article 15: Freedom from Torture or Cruel, Inhuman, or Degrading Treatment or Punishment; and Article 16: Freedom from Exploitation, Violence, and Abuse.

Considering the existing literature, one professional who implemented an approach developed by adapting OD in Vermont, USA, described OD as less exhausting and more humane because it does not involve taking away people's freedom or autonomy (Florence et al., 2020). Furthermore, OD is featured in the Council of Europe's compendium of good practices aimed at eliminating coercive practices in mental health settings as a matter of human rights (Gooding, 2021).

Finally, participants in this study observed that practicing OD facilitated the client's inclusion into their network and community by working collaboratively with them. These findings suggest that OD can be considered to have a significant human rights impact, aligning with Article 4 of the CRPD, which emphasizes general obligations to closely consult with and actively involve persons with disabilities in the development and implementation of legislation and policies. For instance, a UK client described how OD network meetings helped him reconnect with his mother, creating a ripple effect that supported his reintegration into the community (Hodgkins and Debra, 2021). This narrative underscores the potential of OD to foster meaningful relationships and support systems that uphold the dignity and rights of individuals.

Furthermore, these observations highlight the broader implications of OD as a method that not only addresses immediate mental health needs but also promotes long-term social integration and community participation.

4.3 Teams/policies

In Main Theme 4, where challenges and compliments were mentioned at multiple levels, participants suggested personal reflection, supervision, and connections within the team as solutions to overcome the confusion associated with OD implementation. This opinion juxtaposes the suggestion that ongoing and effective supervision is crucial for sustaining OD (Jacobsen et al., 2023). This is also consistent with the suggestion that trust among team members is a prerequisite for OD practices, which require mutual acceptance and attunement (Lagogianni et al., 2023).

In qualitative findings, this opinion moves into the need for organizational culture change. There are reports that network meetings within hospitals have been difficult to implement because of the hospital's hierarchical culture and innate goal of alleviating symptoms. This is consistent with the opinion that integrating OD into existing treatment settings can be challenging due to differences in underlying assumptions and values (Ong et al., 2019), and with the opinion that it may be even more difficult in psychiatric clinical settings where academic theories and expert models are applied to individual suffering (Schütze, 2021).

However, there are also studies that have shown positive effects when OD is applied in a modified form in a hospital setting (Rosen and Stoklosa, 2016; Ritva et al., 2018); therefore, it is also proposed that OD should be considered in a form that is tailored to the circumstances of the institution (Heumann et al., 2023), and that even if only some aspects of OD are introduced, there is value in doing so (Schütze, 2021). In order to shift the culture of care in this direction, it has been suggested that organizational and leadership-level changes are required, particularly by cultivating cultural change and adaptation and by continually removing organizational obstacles, which can be done by holding the anxieties and frustrations of different parts of the organization (Lennon et al., 2023). In order to achieve this organizational change, the criteria (Olson, 2021) for organizations that want to adopt OD can be a significant reference.

At a higher level, there were many comments about the need for policies and budgets for OD to be established; the results of this study present a policy proposal, and it is necessary to include policy guidelines that address this need. For example, the same qualitative findings from this study— that OD practices can result in time-consuming overtime and confusing legal liability—are echoed in other studies (Heumann et al., 2023).

Other qualitative comments about the need for formal training, guidance to maintain psychological continuity under fragmented services, and funding for sustainable implementation also suggest the need for policy change at multiple levels. The example of the UK ODDESSI trial (Razzaque, 2021), where training and implementation are conducted within the context of a large national research platform, can be an important reference. Further, the top-down implementation in Italy (Macario et al., 2021; Pocobello et al., 2024), driven by eight mental health departments, can also serve as a reference for policy design.

These multilevel qualitative findings resonate with the suggestion (Aarons et al., 2011) to consider the individual, organizational, and system levels in policy planning. In the context of South Korea, with the aforementioned recommendations of the National Human Rights Commission (National Human Rights Commission of Korea, 2021) and the inclusion of WHO QualityRights in the new Mental Health Policy Innovation Plan (Kim, 2023), the R&D project, including this study, has the potential to become a new platform for OD to be implemented. QualityRights is similar to OD and participatory in that it involves all stakeholders—professionals, service users, and families—in a collaborative way (World Health Organization, 2019), and has been shown to be effective in improving service quality and human rights when applied to systems in a region (Pathare et al., 2021).

The significant emergence of human rights-related subthemes in main theme 3 of the qualitative findings may be related to the fact that this study was not an OD training alone but was combined with other QualityRights trainings such as Non-Coercive Treatment and Supported Decision Making. We can also assume that the mixed-stakeholder trainee group setting recommended by QualityRights contributed to the extraordinary sense of solidarity in this workshop. This points to the potential for complementarities between WHO QualityRights and OD and suggests the need for further research.

5 Strength and limitation

This study has several strengths. Firstly, the longitudinal design allowed for the observation of changes in participants' experiences and opinions regarding OD practice over a year following the workshop. This provides valuable insights into long-term impact of OD practices. Secondly, to maintain adherence to core OD principles and elements, the author (SK), with formal training and trainers' training, led the pilot practice under the supervision of international experts, promoting the fidelity of the OD practice. Lastly, few studies have explored the relationship between OD and human rights. The study highlights its potential as a human rights-aligned approach, emphasizing its importance in mental health services.

However, the study also has some limitations. Firstly, the small number of participants (n) limits the interpretation of quantitative results. Future studies should include larger sample

sizes to enhance statistical power and generalizability. Secondly, the institutions involved in this study had a strong culture of recovery practice, which may not reflect typical South Korean institutions. Participants' familiarity with human rights principles might have influenced the outcomes. Thirdly, not all participants practiced OD, and the study includes relatively few opinions from those who did not implement the approach, making it difficult to understand their barriers to practicing OD. Future research should focus on these participants to gain insights into the challenges faced. Lastly, due to resource constraints, interviews were not conducted. Although participants provided detailed responses to open-ended questions, future studies should incorporate interviews to obtain more in-depth results.

6 Conclusion

The conclusion of this preliminary study regarding the formal introduction of OD as part of the WHO QualityRights service package in South Korea can be summarized as follows.

Because the great success of OD in Lapland is considered to be based on high-quality training (Putman, 2021a), full-scale training inside the formal system is necessary to successfully introduce OD. This is preceded by the need to increase social awareness and consensus among stakeholders regarding OD. However, owing to the nature of OD, it is difficult to convey the core principles only through literature or lectures; this potentially leads to confusion or resistance due to misconceptions (Lorenz-Artz et al., 2023).

This study shows that even a short, well-planned, and well-designed introductory workshop can significantly motivate participants unfamiliar with OD and provide clues as to what the key learning agent of the introductory workshop should be.

Empowering and motivating participants through OD workshops has a multifaceted, positive impact not only on OD practices but also on the way participants work as well as on teamwork in traditional settings. Further, from a human rights perspective, these changes can have practical implications that translate values into real service in many ways. In this respect, the study provides new evidence to support OD as a good human rights-based service.

The study could be a new example of OD being disseminated as a top-down policy by a country's R&D projects and also the first case of OD being introduced as part of the WHO QualityRights service package. In this unique context, the study implies that OD and this global human rights-based mental health project have the potential to complement each other.

Data availability statement

The original contributions presented in the study are included in the article/Supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving humans were approved by Ajou University Hospital Institutional Review Board (AJOUIRB-SB-2023-173). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

SC: Writing – original draft, Writing – review & editing, Conceptualization, Data curation, Formal analysis, Investigation, Methodology. YHC: Writing – original draft, Writing – review & editing, Conceptualization, Data curation, Formal analysis, Investigation, Methodology. JSN: Writing – review & editing, Conceptualization, Project administration, Funding acquisition. SKJ: Writing – review & editing, Conceptualization, Project administration, Funding acquisition, Formal analysis. SKK: Writing – review & editing, Conceptualization, Methodology, Supervision. SK: Writing – original draft, Writing – review & editing, Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Validation.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2024.1426122/full#supplementary-material

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The introduction and implementation of open dialogue in a day center in Athens, Greece: experiences and reflections of mental health professionals

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Introduction: The present study is part of a large-scale original action-research project aiming to assess the introduction and implementation of the Open Dialogue approach within the clinical practice of an established multidisciplinary team in a Day Centre in Athens, Greece. More specifically, it aimed to explore the experiences of professionals within the process of implementation both in relation to their clinical practice and their professional identity.

Methods: Data collection employed a focus group, which was set up to explore professional reflections of the implementation and research processes since the introduction of the model. Thematic Analysis of transcripts revealed two main themes that correspond to the impact of Open Dialogue on professionals' clinical practice and on team dynamics, respectively.

Results: Professionals identify several challenges in implementing OD, such as difficulties in linking theory to practice, containing uncertainty, and addressing cultural barriers to dialogical ways of working. Professionals further reflect on their own internal journey stemming from the implementation of Open Dialogue that has led them to greater openness and growth, personally and as a team.

Discussion: The role of mental health professionals is being acknowledged as being at the frontline of any meaningful psychiatric reform through the assimilation and promotion of humanistic paradigms aiming towards a change of culture in psychiatric care across different contexts. Despite variations in implementation across different contexts, the importance of consolidating and embracing Open Dialogue as a philosophical framework underpinning mental health care is being discussed.

KEYWORDS

open dialogue, implementation, mental health multidisciplinary team, action research, interpersonal dynamics

1. Introduction

The Open Dialogue approach constitutes an alternative to traditional psychiatric care for individuals experiencing mental health difficulties, particularly psychosis, and marks an inherently democratic shift in mental health care by introducing service user social network

(including mental health professionals) as an integral element of their recovery and psychosocial rehabilitation. Open Dialogue is distinct from conventional approaches to mental illness in that mental health crises are understood as relational—existing in the relationships between people—as opposed to individualistic—located solely within the individual; equally, the goal of therapy is not to treat disease but to support dialogue within social networks rather than changing the service user's behavior *per se* (Dawson et al., 2019).

Existing limitations of the biomedical model and the often-ambivalent attitudes of professionals regarding service user rights further highlight the need for a structural reform in psychiatric care aiming at the democratization of mental health care (Stylianidis, 2019a,b; Florence et al., 2020). The Open Dialogue approach re-conceptualizes dominant notions of mental illness and underpins an essential move towards psychiatric reform and service user empowerment that values service user and family member experiences as important knowledge bases (Gordon et al., 2016). In that respect, Open Dialogue is not only a novel psychotherapeutic approach but also proposes a new way of organizing and structuring responsive and coherent mental health services that ensure continuity of care (Buus et al., 2017; Dawson et al., 2019).

The Open Dialogue approach and its role in the prevention of relapse and promotion of mental health has been systematically applied in Scandinavian countries, Northern Europe, Australia and the US with culturally specific modifications in order to adapt to different mental health services and contexts (Buus et al., 2017; Gidugu, 2017; Stockmann et al., 2017; Dawson et al., 2019, 2020; Tribe et al., 2019; Florence et al., 2020). The role of mental health professionals is being acknowledged as increasingly vital in promoting the psychosocial integration of service users and in challenging dominant psychiatric paradigms (Buus et al., 2022). In that respect, mental health professionals are at the frontline of a meaningful implementation of Open Dialogue through the assimilation and promotion of democratic, humanistic principles aiming towards a change of culture in psychiatric care across different contexts.

1.1. Implementation of open dialogue across different cultures

Most studies on OD implementation attempts have taken place in Scandinavian countries (Buus et al., 2017), with few qualitative studies focusing on the experiences of mental health professionals in introducing or implementing Open Dialogue in their clinical work, across other cultural contexts (Dawson et al., 2020).

1.1.1. Implementation of OD in Scandinavian and Nordic countries

Buus et al. (2017) undertook a scoping review of OD implementation studies across Scandinavian countries. Thylstrup (2009) reports that whilst service users ascribed much value to relationships and in transcending social isolation as a result of Open Dialogue interventions, staff found it challenging to collaborate with professionals from other disciplines, and often felt inadequate in providing Open Dialogue. Similarly, Johansen and Bille (2005), report that the purpose and aims of network meetings were not always clear to network members, nor was the professionals' level and type of engagement primarily due to the cautious attitude of professionals towards the approach. The authors suggest that the Open Dialogue approach ought to be used in families whose thinking is somewhat aligned with such an unconventional approach to mental health, thus posing the issue of therapeutic match between approach and client. Sjømæling (2012) further reports that professionals felt that network meetings were personally challenging because of high levels of uncertainty and disclosure. Such professional uncertainty with regard to the level and type of involvement is also reported by Piippo and Aaltonen (2008), who found that participants who had received Open Dialogue interventions described mistrust in situations where the professionals' team was experienced as either over-involved or uncertain and ambivalent in taking decisions. Similar research reports that whilst mental health professionals overall seem to evaluate the Open Dialogue positively in enhancing their clinical skills and attitude, they nevertheless struggle with abandoning their usual expert role and with maintaining a not-knowing stance towards the outcome of dialogical position (Brottveit, 2002; Bjørnstad, 2012; Schubert et al., 2020).

Johansen and Weber (2007) report resistance towards the implementation of OD at an individual, organizational, and professional level. Clinicians in their study found it challenging to refute their expert role and establish a new type of expertise that would both accommodate the non-hierarchical structure of the approach as well as maintain their professional identity. Similarly, Sondergaard (2009) reports that despite attempts to implement the Open Dialogue approach in a small outreach mental health team in Denmark, professionals eventually abandoned the project during the process of its implementation. Holmesland et al. (2010) and Holmesland et al. (2014) also explored the experiences of healthcare professionals working in a dialogical way. Findings revealed that professionals were able to develop a trans-professional identity and role, however the greatest challenge was to foster the professionals' ability to genuinely listen. Interestingly, less experienced professionals without formal therapeutic training were reported as being better able to integrate Open Dialogue skills into their practices, a finding also reported by Clement and McKenny (2019).

Overall, findings from Nordic and Scandinavian countries suggest that the introduction of Open Dialogue often generated resistance from practitioners, whose position and identity were challenged in several ways; in some cases, findings implied a lack of genuine engagement and understanding of dialogism by professionals. Finally, reports highlighted that not everyone experienced Open Dialogue positively. For example, families with a strong belief in authority and an expectation of being directed by mental health professionals may find the open format of the approach confusing and frustrating. The small body of research examining Open Dialogue implementation in Scandinavia suggests that the adoption of the Open Dialogue principles require significant organizational change, which may in turn generate organizational, professional and personal resistance (Buus et al., 2017).

1.1.2. Implementation of OD across other cultural contexts

There is very little research from non-Scandinavian countries regarding the introduction of Open Dialogue and no extensive reviews on implementation and organizational processes (Dawson et al., 2019, 2020; Freeman et al., 2019; Florence et al., 2020).

In a couple of Australian studies, Dawson et al. (2019, 2020) report that despite professionals' openness and supportive attitude towards the approach, existing organizational ideology and structures

clashed with the integration of Open Dialogue principles. Dialogical ways of working were challenged by the dominant medical model and the emphasis placed upon economic efficiencies by the organization. These studies highlight the importance of a 'good' fit between organizational culture and efforts to implement recovery-oriented care (Dawson et al., 2019, 2020). In Canada, Florence et al. (2020) further report that even though Open Dialogue is an approach that challenges power differentials in mental health, power dynamics, issues of authority, status and expertise remained prominent within the professionals' team even after the introduction of the approach. Further, staff reported that whilst giving up power within the treatment setting was positive and liberating, it was somewhat disorienting when it came to issues of risk and suicidality of service users and to re-negotiating aspects of their professional identity (Florence et al., 2020; Schubert et al., 2020). Equally, research on attempts at implementation of Open Dialogue in the United States and the United Kingdom reveals that although Open Dialogue is acknowledged as clinically helpful, training costs and the need to translate OD principles into the local context may constitute barriers to effective implementation (Gordon et al., 2016; Rosen and Stoklosa, 2016; Tribe et al., 2019; Kinane et al., 2022).

1.1.3. Implementation of open dialogue and organizational change

Taken together, implementation studies suggest that the adoption of Open Dialogue requires significant organizational change. Research on implementation attempts outside Scandinavian countries, further highlight the importance of context and culture and the ways in which such parameters may affect effective and long-term implementation. Still, the paucity of research across different cultural contexts limits our understanding of the perceived benefits and challenges to fully implementing OD-informed approaches successfully (Dawson et al., 2019, 2020; Freeman et al., 2019; Florence et al., 2020). The relative success or failure of any implementation may be attributed to diverse social, cultural and organizational factors including the broader social, economic, cultural and political contexts (Damschroder et al., 2009; Dawson et al., 2019, 2020). The available research emphasizes the need for careful organizational consideration and commitment in order to ensure that the professionals involved both understand Open Dialogue and find it an acceptable and realistic socio-cultural fit to local conditions (Gidugu, 2017; Dawson et al., 2019; Ong et al., 2019; Tribe et al., 2019).

Variation in models of Open Dialogue across different settings, heterogeneity of methodologies following the implementation process and lack of consistency in implementation strategies mean that thorough descriptions of implementation are still lacking in the literature and that more research is needed to support implementation efforts as well as organizational and professional adjustment to dialogical ways of working (Freeman et al., 2019; Twamley et al., 2021). Organizational change transcends through different stages and impacts employee values and dynamics (Aarons et al., 2011; Hussain et al., 2018), whilst the outcome of any reform is mediated by professional attitudes towards change, anticipated gains and the quality of the management in containing tension. It is particularly helpful for facilitators of change to maintain ongoing communication and transparency among everyone involved, in order to disseminate information, reduce team anxiety and promote a sense of inclusion as well as psychological and practical commitment (Herscovitch and Meyer, 2002; Weiner et al., 2008; Tribe et al., 2019).

1.2. The role of mental health professionals

Research suggests that overall, the OD approach is being welcomed by professionals as a good and inspiring alternative to conventional mental health practices; Open Dialogue seems to be appreciated by mental health professionals, as it socializes them into a dialogical and reflective way of being with the other, characterized by understanding and a willingness to share aspects of oneself (Holmesland et al., 2010, 2014; Buus et al., 2017, Galbusera and Kyselo, 2019; Kinane et al., 2022).

Drawing from Mikhail Bakhtin's views on dialogism and polyphony (Bakhtin, 1986; Anastasiades and Issari, 2014), the Open Dialogue approach essentially challenges mental health professionals to adopt dialogue and polyphony as the primary vehicle for constructing meaning and change in their clinical practice (Seikkula and Olson, 2003; Stockmann et al., 2017; Buus et al., 2022). Mental health professionals are asked to participate in the dialogue not from a traditional 'expert' stance but through their authentic thoughts and feelings; in that respect, they need to be engaged into active listening, promoting space for whatever emerges from the dialogue, without censoring it (Hendy and Pearson, 2020). The challenges that have been identified around the implementation and practice of Open Dialogue, indeed seem to refer to mental health professionals' difficulties in abandoning traditional professional roles, organizational difficulties in supporting implementation attempts as well as the uncertainty around applying such a relational stance into clinical practice (Buus et al., 2017; Ong and Buus, 2021; Kinane et al., 2022).

In that context, mental health professionals from different disciplines need to challenge their own assumptions around hierarchy and to work towards the cultivation of a democratic culture within the organization (Seikkula and Olson, 2003; Holmesland et al., 2010). Therapist experience and specialization in a specific discipline may indeed be challenging for mental health professionals that are members of a multidisciplinary team as they may actively aim for targeted interventions or solutions perhaps as a means of regulating their own anxiety and need to control therapeutic outcome (Borchers, 2014; Buus et al., 2017; Stockmann et al., 2017; Schubert et al., 2020). Mental health professionals may face challenges in integrating practices that are not taught but rather experientially acquired and require the adoption of a new modus operandi where transparency and acting from a non-expert stance are elementary; further research seems to confirm that Open Dialogue principles may often cause insecurity in mental health professionals that may lead to reduced participation and questioning of the model (Buus et al., 2017; Dawson et al., 2019, 2020; Florence et al., 2020; von Peter et al., 2023).

In this study we will focus on the case of Greece and on the attempts to introduce and implement Open Dialogue within an established mental health service.

1.3. Open dialogue in a day care centre in Greece

The present action-research was implemented longitudinally since September 2018, in collaboration with Panteion University (Laboratory of Psychopathology, Social Psychiatry and Developmental Psychology) and National and Kapodistrian University of Athens (Laboratory for Qualitative Research in Psychology and Psychosocial

Well-being). The study aimed towards an in-depth understanding of the impact of the introduction of Open Dialogue in a multidisciplinary team of mental health professionals in a Day Centre for Psychosocial Rehabilitation in Athens.

More specifically, *the setting* is a Day Centre for Psychosocial Rehabilitation, a community mental health unit for adults suffering from serious mental health disorders and their families. The multidisciplinary *team* consists of psychiatrists, psychologists, social workers, occupational therapists and psychiatric nurses. Professionals had not attended any certified training in Open Dialogue except for brief introductory seminars delivered online, by Scandinavian colleagues, who had a long experience in the implementation and practice of Open Dialogue. Further, participants were acquainted with Open Dialogue experientially, through the establishment of a weekly Open Dialogue discussion group, a forum created by professionals themselves that aimed at the familiarization, self-education and self-reflection on Open Dialogue practices and any other issues and dynamics that emerged as a result of implementation attempts (Hopper et al., 2019).

The introduction and implementation of the Open Dialogue in the Day Centre has developed over the course of 5 years and can be conceptualized in two phases namely, an earlier phase and a later phase. The aim of the present paper is to present the later phase of the study which focuses on the experiences of professionals within the process of implementation both in relation to their clinical practice and their professional identity. However, as this is a five-year long project, which represents an ongoing, internal process from the part of professionals in relation to Open Dialogue, it seems important to provide a brief summary of the earlier phase of the study in order to depict the development of the journey.

The early phase extended from September 2018 to January 2020. During the early phase two distinct main themes were identified that correspond to two separate time periods with regard to the early phase of the study. Taken together, main themes and subthemes create a coherent story about the team's journey with Open Dialogue over time (Skourteli et al., 2019, 2021).

During the "*Introductory-Exploratory' period* the multidisciplinary team felt that was in a position of passivity and disempowerment regarding the implementation of the Open Dialogue approach. The research itself was viewed as part of a vertical hierarchy that imposed the new approach; group dynamics were affected, and initial stages of the introduction were marked by anxiety and suspicion around issues of authority and power. Ambivalence towards the new model was initially expressed through a depreciation of the approach as introducing "nothing new" to treatment as usual (Sondergaard, 2009; Holmesland et al., 2014). The team initially attempted to manage the introduction of the Open Dialogue approach by equating and assimilating it to already existing representations and practices by actively seeking points of convergence between established and novel approaches. Although attractive, the democratizing and deeply reforming nature of Open Dialogue appeared to evoke insecurities with professionals feeling unprepared to engage with it (Skourteli et al., 2019; Stylianidis, 2019b; Schubert et al., 2020). These initial findings seem consistent with literature highlighting the resistance of mental health professional teams in assimilating Open Dialogue as part of their professional practice (Sondergraard, 2009; Thylstrup, 2009; Holmesland et al., 2010, 2014; Seikkula, 2011; von Peter et al., 2023).

Over time, during the '*Introductory Systematizing*' period, following significant structural and systemic changes within the service—along with the researchers' sharing of preliminary findings with the OD team—mental health professionals seemed to gradually move from a position of passivity to one of responsibility and agency with respect to the introduction of the Open Dialogue approach. Monthly team supervision, introduced as part of the research protocol significantly facilitated the necessary space for reflection and supported the Open Dialogue team in becoming more defined. Over time, the Open Dialogue team was able to better integrate dialogical ways of being into their identity and practice, whilst maintaining a realistic view of the challenges and ongoing needs (Skourteli et al., 2021). For a more detailed account of earlier phases of the research, see Skourteli et al. (2019, 2021).

The later phase of the research project presented here, focuses on the overall stocktaking, experiences and reflections of professionals on the implementation of Open Dialogue as well as the challenges and main issues that emerged throughout this process.

2. Methodology

The overall project employs an action-research methodology following the introduction and implementation of the Open Dialogue approach within a multidisciplinary team of mental health professionals. Action-research seems an appropriate choice of methodology, since it seeks transformative change in the clinical and organizational aspects of the mental health service presented here, through the simultaneous process of taking action (OD implementation) and doing research, linked together by critical reflection. As its goal is oriented towards organizational change, the knowledge produced and actions undertaken inform each other in cyclical ways over the process of the research (Stringer and Genat, 2004; Issari and Polyzou, 2013).

2.1. Participants

In the later phase of the study participated 11 professionals (four psychologists, two psychiatrists, two social workers, an occupational therapist and two mental health nurses). None of the participants had attended any formal OD training but were attending monthly external supervision for the past 2 years, with two senior colleagues that had completed the structured 3-year OD training in the United Kingdom Inclusion criteria for therapists included the implementation of the OD approach in their practice.

2.2. Data collection

A focus group was set up that consisted of professionals implementing Open Dialogue principles in their clinical practice. The aim of the group was to explore the overall experience of the implementation process within the service as well as to review and reflect upon the professionals' journey with Open Dialogue. The focus group was facilitated by the senior researcher overlooking the study (MS) and lasted approximately 2.5 h. The facilitator initially introduced broader questions on the impact of implementation before exploring more specific aspects of participants' experience. Questions aimed at eliciting narratives on the development and implementation of the Open Dialogue approach within the Day Centre. Some examples included: what is your experience of Open Dialogue? how has your experience evolved over time? how has Open Dialogue affected your

clinical practice? what are the gains and challenges of implementing this approach? how was your experience of participating in the current research whilst implementing a novel approach? Participants were encouraged to express their experiences and to interact with each other, as the latter prompted new questions that clarified individual and shared perspectives. The focus group was conducted in order to uncover a shared understanding of how aspects of Open Dialogue was implemented and to capture interactions and contrasting perspectives amongst participants (Buus et al., 2022). The focus group was audio-recorded and transcribed verbatim by the senior researcher with indications of basic turn-taking features, including interruptions and overlapping speech (Tong et al., 2007). The quality of the transcripts was assessed by comparing transcriptions to audio recordings, with the help of a second senior researcher, specializing in qualitative research methods, which led to a few corrections of details of the transcripts.

2.3. Ethics statement

The present study took place with the informed consent of all participants. The nature and aims of the study were thoroughly explained to members of the multidisciplinary team and written consent was obtained, whilst participants maintained their right to withdraw from the research process until the point of verbatim transcription of the focus group. Collected data were coded to promote anonymity and confidentiality of all participants and were stored electronically in password-protected files only accessible by the researchers; following completion of the research, all data will be permanently destroyed. Finally, participants of the focus group were debriefed about the research process in order to promote transparency and inclusion in the research process (Howitt, 2010; Emerson et al., 2011; Issari and Pourkos, 2015).

2.4. Data analysis

Thematic analysis with an experiential and realist orientation (Braun and Clarke, 2006) was utilized for the analysis of data produced from the professionals' focus group. Audio recordings of the focus group were transcribed verbatim, and transcripts were analyzed inductively in order to reflect the experience of participants. Transcripts were read and re-read by researchers in order to generate some initial codes which were then organized into recurrent patterns or themes in what is being discussed. Produced themes were then reviewed and refined to ensure that themes cohered meaningfully whilst reflecting distinct and identifiable entities that correspond to participant narratives. The researchers followed Braun and Clarke's (2006) six steps which included familiarization with the data, generation of initial codes, searching for themes, reviewing potential themes, defining and naming them.

3. Results

Themes that were produced from thematic analysis of the focus group highlighted the impact that Open Dialogue has had not only upon professional clinical practice, but also on group dynamics and team processes over time. Professionals were able to verbalize clinical concerns and to maintain a critical stance towards the Open Dialogue approach. The participation in the present action-research itself seems to have facilitated team openness and growth both professionally and personally. Overall, two master themes were produced from data analysis with seven corresponding subthemes (three and four subthemes respectively). Table 1 outlines the master themes and subthemes that were produced from the thematic analysis of the professionals' focus group.

3.1. Impact of implementation of OD on clinical practice

The first master theme highlights the impact of the introduction of Open Dialogue upon professionals' clinical practice. A prominent challenge refers to difficulties linking OD theory and practice, whilst there is an acknowledgement of the experiential aspect of the approach. Professionals are better able to question their stance towards uncertainty and how this may impact ways of being with clients, whilst maintaining a critical stance about the universality of OD and raising the important question of what works for whom in psychotherapy.

3.1.1. Difficulties in linking theory with practice of OD

Professionals expressed their difficulties in bridging the theoretical aspects of Open Dialogue and applying them in their clinical work with clients. This is most likely the outcome of a lack of formal OD training amongst professionals, which may be particularly accentuated as service users' mental health is often severely affected upon referral. Professionals refer to a sense of ambiguity around ways of being with clients, particularly the notions of therapist reflection and transparency in network meetings.

> *'… It appears to be ideal and captivating when I read about the OD approach in theory, in the literature and through the research process. But when the time comes to apply it in the work with a real person in distress, I think to myself-ok, how can I really apply this, how do I do it? It is not something that can just be applied as a set of skills, this seems to a whole new different context above and beyond myself' (P4: extract from professionals' focus group)*

TABLE 1 Master themes and subthemes of professionals' experiences.

Professionals' focus group	
Master themes	Subthemes
Impact of implementation of OD on clinical practice	– Difficulties in linking theory with practice of OD
	– Containing uncertainty
	– Cultural fit between OD approach and service user network
Impact of implementation of OD on professionals' team	– Experience of participating in the research
	– Team openness and growth
	– Challenging team omnipotence and acknowledging own boundaries
	– High turnover of staff

'Sometimes I get the sense, what do I do, what I am I trying to do and to what extent do I understand what I am doing. To what extent am I a part of this … Because having read about it is one thing, but having experienced it is quite different … I think I will only be able to do it when I experience it myself. At least this is what I think … I have never in my life been able to learn something just by reading about it. There is a gap there … So I think this is quite difficult' (P8: extract from professionals' focus group)

'For me, what still remains quite ambiguous is the part around reflective practice … I am always anxious whether it is appropriate to self-disclose, what is my motive, if the other person should hear it, whether it is helpful I mean for them or whether I would like to share something more private … I think it is a fine balance that can be quite facilitative or meaningful, or on the other hand quite harmful I guess …' (P1: extract from professionals' focus group)

'… There is the issue or transparency here, and more precisely even honesty. I can empathize with service user X, I can understand why she is frightened, and I can mirror this-however, when she is telling me about how she is being persecuted by everyone, I cannot confirm this … Perhaps this is something lacking in my training theoretically and practically. Psychotherapy is supposed to be about the reality principle … now you are going to think, which reality? Reality is how the other feels or thinks she feels I guess …' (P10: extract from professionals' focus group)

3.1.2. Containing uncertainty

Professionals are acknowledging the containment of uncertainty and a not-knowing stance as a valuable albeit difficult aspect of the Open Dialogue approach. They are able to reflect on their stance towards knowing and not-knowing stemming from their own anxieties and need to remain in control.

'There were times where I felt that my capacity for containing uncertainty was exceeded in relation to the psychotic symptom. It is quite frightening to get into people's delirium … It was scary to get into this narrative, it was as though we were one and I couldn't deal with it' (P7: extract from professionals' focus group)

'The way I have been trained, you do not get this deep into the symptom, you focus more on reality and you liaise with the healthy part of the person, so to speak … There have been times with my co-therapist where things got quite scary for me, to get used to this and to find my own space and boundaries within all this-I felt like I was losing myself …' (P7: extract from professionals' focus group)

'There were times where we had to provide a solution because the meetings were revolving around the same themes, the family was stuck, so we needed a little push, a little problem-solving …' (P6: extract from professionals' focus group)

'I think this is about our own issues around working with difficult service users-so I sometimes agree with providing solutions. I think it is related to the severity of the condition as well as our own difficulties with uncertainty, so we resort to more monological interventions-it is safer' (P3: extract from professionals' focus group)

3.1.3. Cultural fit between OD approach and service user network

Participants are maintaining a critical stance towards the universality of Open Dialogue and begin to raise questions regarding the applicability and fit of the approach, both in terms of culture as well as network characteristics and dynamics. In particular, professionals begin to challenge the notion of OD as an ideal therapy and to form more realistic expectations of it. Essentially, the team is reflecting upon the important issue of what works for whom in psychotherapy and raises the issue of how the approach interacts with specific service-user, network and therapist characteristics.

'I think the network determines quite a lot of things, as it affects everything else. It all began from the quality of the network and the mentality of each family. Network X was quite easy to work with because they were quite open, network Y was on the other end of the spectrum …' (P9: extract from professionals' focus group)

'I saw that not everyone had the patience to see where this is all going to lead … Some people were after a solution now, they wanted to get better. I believe they wanted to carry on with OD but they could not wait for so long, they wanted to feel better now and they underestimated everything else …' (P2: extract from professionals' focus group)

'I do not know how to assess this … some families appreciate the small changes stemming from moments in the sessions, others saw nothing helpful at all … I think this is related to the mentality of each family …' (P4: extract from professionals' focus group)

'I think the key is to be able to comprehend the other person's reality and to be able to step in their shoes. Some families cannot do this at all whilst others more so … I think this is an important parameter' (P5: extract from professionals' focus group)

'Internal polyphony sometimes is not possible. And it is usually not possible in families where there is emotional unavailability, there is no connection to feelings …' (P4: extract from professionals' focus group)

'My thoughts are that OD is not a panacea, it is like all other psychotherapies what works for whom? Like in an individual psychotherapy, you would be able to say when making an assessment that psychoanalysis for example is not a fit with this client. Perhaps it is an approach that doesn't suit everyone, I don't know …' (P1: extract from professionals' focus group)

3.2. Impact of implementation of OD on professionals' team

The introduction and implementation of Open Dialogue within an established mental health team seems to have also impacted the dynamics and group processes of the team of professionals over time. The onset of the present action-research and the introduction of the new approach seems to have offered professionals the opportunity to reflect on their own personal, transformative journey over time.

3.2.1. Experience of participating in the research

Professionals are able to reflect upon their experiences of participating in the present action-research and on how this process has evolved over time, especially as Open Dialogue was initially implemented in a top-down manner by the management of the organization. Issues around fears of assessment and anxieties over criticism, although still present to some, seem to have subsided and to have given way to seeing researchers as allies that may operate as organizing and supportive for therapists along the journey of OD.

> *'I never felt that I was being assessed, although the researchers did not speak during network meeting and they were keeping notes, but I never had the feeling of being judged-quite the contrary, what I had in mind is that this person is on our side and she will always have in mind my intention even if I make a mistake …' (P2: extract from professionals' focus group)*

> *'At the beginning I was anxious about what they were writing down, the notes they kept, and I could not focus on the session at first but as time moved on, I began to like this, to experience it as a supportive reminder of the Open Dialogue principles and why we were there, and I was more focused …' (P6: extract from professionals' focus group)*

> *'I saw her more as a third eye in network meetings, she stood at a greater distance compared to me in relation to the client and she could see more clearly … So, I have always been looking forward to receiving feedback … Having another person that is more external to our team, made me more organized and boundaried, even with scheduling appointments …' (P5: extract from professionals' focus group)*

> *'My own feeling was that we were much stricter on ourselves than what we ought to and we expected that somehow from the researchers at the beginning, although this was not the case at all' (P3: extract from professionals' focus group)*

> *'I did not have the sense of being assessed, I was just working in the usual way. At the beginning I did not know whether I should speak to her at all but eventually I felt very connected with her, I felt I had someone to lean on, we were chatting on our way back from network meetings and I experienced all this as very helpful …' (P4: extract from professionals' focus group)*

3.2.2. Team openness and growth

The theme of the multidisciplinary team's openness has been ongoing since the onset of the research project and seems to refer to both an external sense of openness and receptivity towards new colleagues and ideas as well as an internal sense of personal growth. It appears that the team has managed to make a significant shift over time towards a stance of greater polyphony and inclusion that is being experienced as enriching and meaningful, personally and professionally.

> *'We became more open as a team, we opened up to more voices, by letting more people in (the researchers), something like what takes place in network meetings amongst ourselves … Like we usually say in systemic therapy, a closed system is the one that perishes in the end, an open system is adaptive and flexible, and I think this is what has happened in our team … Even conflict is not necessarily destructive and doesn't mean the end …' (P7: extract from professionals' focus group)*

> *'I was thinking about openness, not only therapeutically, but here, in our team, how differently we interact we each other. Our morning reflective exercises even in the presence of new people-we were not used to this, and they were not used to us being open and then they became a part of all this. The openness in our team when the researchers came, that was a significant shift' (P10: extract from professionals' focus group)*

> *'At the beginning of all this journey we were quite closed as a team I think, it was as though we were into a merger. And anything external, coming from the outside, researchers over the years, new colleagues, we felt as though it was threatening because we also had this Ideal about ourselves that we can manage everything and if we can't, then we will be judged for it. We thought we were the best because we can manage everything and if we couldn't then we were the worst. And now, we see that a Third, can enrich us and organize us and we are quite welcoming of this now. I think there has been a great transformation in our team over time, since the introduction of Open Dialogue' (P1: extract from professionals' focus group)*

3.2.3. Challenging team omnipotence and acknowledging own boundaries

The introduction of Open Dialogue in a team of experienced mental health professionals, along with the lack of training in the particular approach, seems to have challenged professionals' sense of expertise, authority and professional identity. Over time, professionals have been able to reflect upon their own professional identities, sense of omnipotence and anxieties over incompetence and criticism (something that may be an outcome of the wider organizational culture), to acknowledge their own limits and to move towards more realistic and meaningful ways of relating to themselves and others.

> *'The longer you work with OD, the more you open up space for your own internal polyphony. And I think being able to hear more aspects of yourself, acknowledging our own limitations and keeping our expectations realistic allows us to say, well this is all that I can do,*

> *this is what I can. And I think this is a qualitative change in our team and in every single one of us…' (P9: extract from professionals' focus group)*

> *'This year, I saw a change within myself, I do not need to hold people under my wing, I am more ready to acknowledge endings and limits. At some point I did say to my co-therapist, this is enough, we did what we could with this family, which is something I didn't have before. On one hand, we are no longer after a quick result or an impressive change, we give time and we acknowledge small changes but then there comes a time when time is over, and this is ok …' (P8: extract from professionals' focus group)*

> *'We are able to put better boundaries at some point and this older sense that we must have all the answers and solutions otherwise we are bad at our work, we gradually abandon this sense of omnipotence that we are ideal and must be able to manage everything' (P3: extract from professionals' focus group)*

3.2.4. High turnover of staff

Participant narratives reflect that the introduction of the Open Dialogue approach is being experienced as having had a significant impact on the organization as a whole and particularly so, amongst the professionals in the Open Dialogue team. There were significant role changes across all levels of the organization, with a number of colleagues departing from the Open Dialogue team either as a result of conflict, promotion to higher management or due to changes in their personal circumstances. For a short period of time, there was a high turnover of staff in the OD team, with several colleagues joining and then leaving the team within a brief period of a few months, something that seems to have caused a sense of discontinuity and instability amongst professionals. Participants are reflecting upon this period and the ways they feel that organizational changes may have impacted their clinical practice.

> *'The first thing that comes to my mind is the departure of colleagues from the team that upset the balance of the therapeutic couples I think and it did cause a discontinuity for a while … A lot of changes took place over time not only in our OD team but also the organization. Many people left, others changed roles and all this on top of the severity of our clients' mental health can cause a lot of people leaving …' (P5: extract from professionals' focus group)*

> *'Since our team changed, with all these departures of colleagues, I got this sense that we will, well and we did, I think, regress to an earlier stage and we were closer to ACT rather than OD. It was around the time when people left, and new people came into the team and I had mentioned it then in our meetings that we became more ACT than OD for a while …' (P6: extract from professionals' focus group)*

> *'Well yes, this does make sense, when a system is de-stabilized it is inevitable that it will move towards what is familiar to be able to find its balance again, to find its base before venturing out again and I think the high turnover of colleagues in our team made us, very wisely I think, regress to what we knew best, to maintain our self-esteem until the team is restored and new members are integrated …' (P3: extract from professionals' focus group)*

4. Discussion

The present study is part of a larger action-research exploring the introduction and implementation of OD within the clinical practice of a multidisciplinary team of mental health professionals. The present study aimed at exploring the subjective experience of professionals in the process of implementing aspects of OD in their practice as well as of taking part concurrently in the action-research, aiming to support the introduction and implementation of OD initially in the context of the Day Centre and later in the wider organization of E.P.A.P.S.Y. (Dawson et al., 2020).

Findings from the professionals' focus group suggest that the implementation of OD has impacted mental health professionals across two main areas: their clinical practice and the group dynamics in the OD team.

Mental health professionals in this study expressed a difficulty in linking the theory with the practice of OD, especially with respect to implementing dialogical ways of being with others, particularly when working with service-users in crisis. The notion of reflective practice is regarded as crucial; however, professionals appear uncertain as to how to maintain appropriate boundaries between genuine, reflective practice and self-disclosure. Equally, maintaining a not-knowing stance is acknowledged as the greatest challenge for therapists, particularly under difficult circumstances where regressing to pre-existing psychiatric practices and notions of expertise relieve professional anxiety and restore a sense of control over the therapeutic process (Seikkula and Olson, 2003; Skourteli et al., 2019; Stylianidis, 2019b). Therapists in the present study report that containment of uncertainty was experienced as an absence of pressure to respond immediately to both network and their own expectations of themselves as omnipotent therapists, both during each meeting and overall, during the service user's course of recovery. Sometimes the use of monological responses around critical issues of medical care and risk to self or others (as in cases of domestic violence) was deemed as necessary, however therapist attunement, flexibility and capacity to adjust to the ongoing network needs allowed them to gradually restore a dialogical stance (Borchers, 2014; Stockmann et al., 2017; Schubert et al., 2020). Although these challenges are most likely due to the lack of experience and formal, systematic training in OD, they are consistent with findings reported in the literature. According to Seikkula (2011), a significant portion of experienced and skilled mental health professionals present difficulties with the notion of dialogism since this is not a method or a technique but a way of being with others. In that respect, therapists who are required to participate in a meaningful, embodied and genuine way in the here-and-now, may often feel uncertain as to the experiential ways of implementing a dialogical stance (Seikkula and Arnkil, 2013; Buus et al., 2017, 2022; Ong and Buus, 2021; Kinane et al., 2022).

The notion of a cultural fit of Open Dialogue across different cultural and social contexts was acknowledged as an important

parameter to be taken into account by participants in this study. Professionals seems to develop a less idealized view of Open Dialogue and to gain a more realistic view of what works for whom in psychotherapy (Norcross and Wampold, 2011). Participants report that the mentality and relationships among different members determine the quality and openness of the dialogue during network meetings. Further, the attitudes, culture and philosophy of each network seems crucial in the communication, sensitivity, and openness towards dialogical interventions; this is consistent with literature posing the issue of a realistic therapeutic and cultural match between approach and client (Johansen and Bille, 2005; Ong et al., 2019; Tribe et al., 2019). For example, Buus et al. (2017) report that families with a strong belief in authority and an expectation of being directed by mental health professionals may find the open format of the approach confusing and frustrating. Indeed, bearing in mind the Hellenic culture that values hierarchy and expertise, some families in the present study both expected and insisted on receiving direct advice and solutions from co-therapists and seemed to be lacking the capacity to contain the dialogical aspect of the interventions; for such networks, polyphony was viewed as chaotic, unhelpful and confusing thus preventing opportunities for observing small changes in the dynamics of the network over time. In cases where therapists resorted to more monological interventions, they report that it was their capacity to internally maintain a dialogical stance that allowed them to restore polyphony when the networks' capacity to accommodate them was reinstated; this recommendation has also been made by Ong and Buus (2021). Professionals' reflections from the focus group in the present study seem to suggest that therapists from different theoretical orientations utilized OD as a basis for integrating other aspects of psychotherapeutic practice according to individual networks' needs (Seikkula and Arnkil, 2013; Buus et al., 2017; Dawson et al., 2019; Freeman et al., 2019).

Findings produced from the professionals' focus group suggest that the introduction of Open Dialogue within the service continues to have a potent impact on group and organizational dynamics. Participants are reflecting and taking stock of the growing openness of the OD team over the past 5 years since the introduction of Open Dialogue in the service of the Day Centre. This openness essentially refers to the developing polyphony in the professionals' team and within each participant separately, regarding new ideas, new people as well as several systemic changes within the organization. It also refers to an internal shift from a position of mistrust to a more open relational and philosophical stance towards self and others that may reflect the significant personal journey towards becoming a dialogical therapist. The experience of participating in the present research also appears to have changed over time; the professionals' team seems to have moved away from fears of inadequacy and criticism to seeing the research as supportive of the implementation and as a valued opportunity for ongoing personal and professional development (Galbusera and Kyselo, 2019; Buus et al., 2022).

This process of becoming a dialogical therapist further seems to be reflected in the acknowledgement of boundaries and limitations of the professionals' team, as produced by participant narratives. Therapists appear to be challenging the omnipotence and idealized view of team (as well as Open Dialogue approach itself) encountered in the early phases of the study and to be moving away from notions of monology, authority and expertise towards a position of greater internal and external polyphony.

Looking back, it appears as though the introduction of the Open Dialogue approach in this multidisciplinary team of mental health professionals has instigated a macroscopic transformative process in aspects of the organization itself. Firstly, it seems to have incited rapid changes in the constitution of the professionals' team as well as a significant structural reform across different levels of management over time. Since such changes were often experienced as traumatic by employees, as reflected by references to the high turnover of staff over the past 5 years, the management of the organization introduced regular supervision (both clinical and group) in order to reduce conflict and promote tolerance and polyphony within the team, as informed by early findings of the study. It needs to be noted here that it was perhaps the lack of formal, systematic training in OD or other organizational characteristics prior and during the implementation process that may have contributed towards the overwhelming impact reported in participant narratives and not Open Dialogue as an approach *per se*. Indeed, over the course of the present action-research, there was ongoing dialogue, reflection and feedback between the research team, participants themselves and the management of the organization, in order to ensure that implementation attempts are guided and co-constructed through polyphony and co-operation across different levels. It appears that a greater investment is being made on the Open Dialogue approach over time through the acknowledgment of the pressing need for formal, systematic training as well as through attempts to expand the implementation of the Open Dialogue approach to other services of the organization (residential, mobile units, etc.), outside the Day Centre.

To sum up, the present action-research seems to have contributed significantly not only to the introduction and implementation the Open Dialogue approach within an established mental health service but also to the exploration of its impact upon professionals and organization with the view to supporting implementation attempts in the long-term. In short, the research presents a coherent story about the team's journey with Open Dialogue over time; this journey may provide insight into the readiness of mental health professionals to adopt aspects of the Open Dialogue as well as the challenges and main issues that may emerge throughout this process.

5. Conclusions and limitations

A significant strength of the present implementation of Open Dialogue in Greece is that it has been developed in close collaboration with the two main Universities of Athens (Panteion University, Laboratory of Psychopathology, Social Psychiatry and Developmental Psychology and National and Kapodistrian University of Athens, Laboratory for Qualitative Research in Psychology and Psychosocial Well-being). The relationship to universities and academic departments has been recommended in the literature for the strengthening and institutionalizing of the Open Dialogue approach and for the development of larger research programs in the field of dialogical practices across different contexts (Buus et al., 2017).

The present paper highlights the pivotal role of mental health professionals in cultivating a new philosophy and practice in psychiatric care through presenting a multidisciplinary team's journey

with Open Dialogue and its transition from a monological to a dialogical epistemological stance. It seems important to highlight that even within innovative mental health organizations that are committed to the principles of recovery and empowerment, there are still significant collective defenses that may stem both from the threat to one's professional identity and the deeply rooted impact of the paternalistic model in psychiatry (Hussain et al., 2018; Tribe et al., 2019; Stylianidis, 2019b).

In particular, the study may contribute towards the identification of the challenges and resistances encountered by mental health professionals with regard to issues of authority, hierarchy and expertise, when asked to engage in attempts that challenge notions of traditional psychiatric care. The findings emerging from the present study seem consistent with those reported in previous research (Buus et al., 2017; Ong and Buus, 2021; Kinane et al., 2022). Buus et al. (2017) report that the OD approach often generated resistance even amongst practitioners with formal training in OD, whose positions were challenged in different ways, although the authors remain skeptical as to whether such resistance is more pervasive compared to any approach that promotes reform of mental health services and includes the re-positioning of users and professional in the treatment setting; the authors go on to challenge the assumption of a universal 'cultural' fit between the OD approach and to acknowledge the characteristics of different networks (Buus et al., 2017). Similarly, Kinane et al. (2022) report that whilst for some service users, reflexive practice was experienced as strange and uncomfortable, professionals found the OD approach a valuable reflective space aiding the development of relationships and dialogue with each other and the acknowledgement of the power dynamics in the professionals' team. Finally, Ong and Buus (2021) address the lack of precision and specificity around what constitutes dialogical practice that may contribute towards the ambiguity and uncertainty often encountered even by trained professionals. Overall, however, participants in the present study report experiencing Open Dialogue as enriching and valuable not only for their clinical practice but primarily for their personal development. Nevertheless, the present study further raises the question of the adaptability of the Open Dialogue approach across different contexts whilst highlighting the organizational parameters that are required for implementation attempts to be viable and sustainable over time. More research in the area certainly seems necessary to highlight challenges and issues encountered during implementation attempts of the model across different contexts.

However, the present study is not without limitations. Firstly, participants in the present study had not received any formal OD training and from that perspective the overall challenges and difficulties encountered may be due to the lack of exposure to experiential aspects of the model such as the use of the dialogical self. Furthermore, the present study included a very small sample of professionals, which may shed some light on a local level on one hand but may make generalization to other contexts somewhat difficult.

A crucial question that may remain is the notion of what works for whom in psychotherapy; as with other theoretical approaches the case may be that OD may be more or less compatible with some but not all service users and their networks, bearing in mind the clinical, cultural, educational and socio-economic variables of each network and setting. Within that, it seems important to safeguard the notion that the theoretical approach fits service-user needs rather than vice versa (Browne et al., 2019). Nevertheless, the perspective of consolidating and embracing Open Dialogue as a philosophical framework underpinning mental health care may further advance ongoing attempts towards psychiatric reform and a change of culture in psychiatric care with benefits on a micro, meso-and macro-levels of society.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving human participants were reviewed and approved by Association for Regional Development and Mental Health Ethics Committee National and Kapodistrian University of Athens Ethics Committee. The patients/participants provided their written informed consent to participate in this study.

Author contributions

MS: organized, implemented and managed the action research, data analysis, writing up of the manuscript. PI: overall supervision of the research protocol and approved manuscript. LD, AA, GB, and AS-T: data collection and analysis, approved manuscript. SS: authorized implementation, overall supervision of the research protocol, and approved manuscript. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Open Dialogue as a cultural practice - critical perspectives on power obstacles when teaching and enabling this approach in current psychiatry

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Building on both therapeutic and organizational principles, adopting Open Dialogue (OD) calls various routines of the current mental health system into question, resulting in potential obstacles with implementation. This perspective paper aims to reflect on power relations as potential disruptive factors in enabling the OD approach in mental health care. Drawing on data from a small implementation study, followed by reflections from three perspectives, we conclude with a discussion exploring the potential of understanding OD as a fundamental human practice to reduce these power-related obstacles.

KEYWORDS

sect, monologue, difference, polyphonie, hierarchy, identity

Introduction

The implementation of Open Dialogue (OD) introduces changes on two different levels: First, a culture of dialogical communication between staff, users, and caregivers is supported, promoting open exchange, transparency in decision-making as well as favoring context-bound understandings over symptoms and clinical diagnostics. Second, community-based, multi-disciplinary teams are organized to offer primarily outpatient services: immediate help in crisis, continuity of support by the same team, a low and selective use of medication and a primarily psychotherapeutically oriented approach are key principles of OD, requiring major structural changes for their implementation in current mental health care systems (Olson et al., 2014).

Building on these therapeutic and organizational principles, adopting OD throws various "paradigmatic givens" of the mental health system into question, which may also lead to implementation obstacles. This tension has been dealt with in more depth in another essay (von Peter et al., 2021) and summarized in a more recent publication describing how the OD approach leads to "challenges between core clinical values, and conflicting expectations of professional practice and performance" (Lennon et al., 2022). As a result, the implementation of OD may "generate organizational, professional, and personal

resistances" (Søndergaard, 2009), leading to major problems in its acceptance and adoption in practice. For this reason, it is important to examine what can modulate such resistances and how OD practitioners or trainers can actually contribute to enabling them or preventing them.

This perspective paper aims to reflect power relations as potential disruptive factors for the implementation of the OD approach in mental health care. It follows the main line of question as to which power emerges from us as OD practitioners and trainers, and how this power makes it more difficult to implement OD. For this purpose, we draw on data from a small implementation study carried out between 2017 and 2018, of which the main results are drawn upon elsewhere (Putman and Martindale, 2022). This study material is first briefly given as a background and then analyzed by the authors from different perspectives. Thereby, we first use rather open, associative reflections, as usually applied during the OD Reflecting Team OD practices (Olson et al., 2014), followed by a more structured discussion, exploring the potential of understanding OD as a fundamental human practice to reduce the power-related implementation obstacles described.

Extracts of study material

The study mentioned was of an exploratory nature, aimed at understanding the doubts and in certain cases resistance of about 2/3 of the members of a training group to implement OD in their daily clinical practice after an extensive training of roughly one and a-half years. This training took place in a university hospital setting, involving trainees from diverse institutional backgrounds, including staff in day clinics and out-and inpatient facilities. Although the training program started with a significant group of approximately 25 persons attending, little by little, the attrition rate progressively climbed from session to session. Upon completion, only 5–8 persons continued to practice OD network meetings on a continuous basis, thus leading to the question of the need to understand the motivations behind the other participants' decision not to engage in this approach.

12 problem-centered interviews were carried out with staff trainees from various occupational backgrounds, asking about the reasons for not further engaging in the OD approach. In most of the interviews, it quickly became clear, that power relations were at the center of what hinders the implementation process, a topic that therefore we have chosen to focus on here. The interview material was re-coded by one of the authors (SvP) to provide for an empirical basis for further reflections on this topic. Only a selection of the relevant passages could be represented in this manuscript due to reasons of space.

Faced with a multitude of definitions and varieties of conceptualization, power will be understood in the sense of Foucault's notion of "capillary power," conceptualizing it as a rather diffuse, generalized potency that plays out in every interaction and exchange and is spread throughout society, instead of using a more top-down definition that understands power as more direct force of domination or oppression (Foucault, 1975). To facilitate understanding, selected quotes from the interviews are given under sub-headings below and integrated within explanatory texts that are of a more interpretative nature. These verbatims are followed by further reflections by each author based on their experiences with OD prior to discussion.

Power games

The interviewees made clear that the OD training polarized teams that had previously been working well together:

> *"Unfortunately, our teams have been divided since the OD training. People first felt energized by the training -[…] but that only went so far, as power games came into play."* (Interviewee (=I)2)

These power games were described as having emerged quite early on over a conflict of competence:

> *"… the wrangling over therapeutic competence between the staff in training and the staff not being trained came into play right from the second training session onwards."* (I3)

Threat to power relations

This dynamic was perceived to result first of all from the very nature of the OD approach, described as threatening to traditional power relations:

> "*The call to make yourself present, transparent, and authentic isn't everybody's cup of tea […] there is always the possibility of being confronted with your own mistakes and the shortcomings of the system. And there is the danger […} that your own expertise is no longer the most important."* (I7)

And:

> "*OD is incompatible with the current system that does not cherish controversy at all. Traditional structures demand clear definitions and orders… OD is much less hierarchical, more horizontal. […] Letting go of that power can be quite liberating, but also intimidating."* (I8)

Know it all

Second, these power dynamics were thought to derive from the particular behavior of the OD practicing staff, in particular from its perceived attitude to know everything better:

> *"I think that there is a danger that people who practice OD see themselves as superior and this can be experienced as a provocation… as if in their infinite wisdom they know it all or they are better than other staff."* (I9)

And:

> *"The people who practice OD convey the idea that everything else aside OD is or has been wrong or worth less. They are on a mission to convince all the other staff to practice only OD." (I6)*

What are their motivations?

This behavior led to mistrust and accusations that the OD staff lacked transparency in terms of their motivation:

> *"Sometimes, it is not clear to me, what do these OD people want? What are they up to? What is their goal?"* (I2)

And:

> *"…they claim that everything is possible – for instance using the notion of polyphony or rejecting hierarchies – but actually there is a hard and fast line of what is allowed and what is not."* (I6)

Reflections of the authors

To increase the polyphony of interpretation, in the following, the empirical material is reflected upon by the three authors of this manuscript, providing for various ideas, images, feelings, and associations that have arisen, when reading and discussing the empirical material. This form of "inner dialogues" or "reflective talk" is frequently used during practicing OD (Olson et al., 2014), meant to use various styles and rhetoric with the goal to elicit multiple viewpoints and to escape the risk of too monolithic interpretations *via* an assemblage of emergent thoughts and divergent associations. In the discussion part, these reflections will be integrated into a more coherent narrative that reflexively deals with possible solutions to reducing the power-related implementation obstacles described.

Sebastian

I want to begin my reflection by describing a recent experience: I went to an OD community center to check its suitability as a research center. Normally I am very critical when I visit clinical facilities. Here the opposite was the case: I was open, felt at home, was in direct contact with the staff. After this visit I felt bad, and I did not know why. Only gradually, I realized that during this visit, I had functioned as part of an idealized community.

While I usually keep a critical distance from psychiatric services of any kind, I felt fully immersed in this situation without any "ifs and buts": I rather freely related to my OD colleagues, checked their attitude much less critically than in other situations and used fewer precautions to protect myself. Coming from a heavy Nazi background on both sides of my family, such an immersion had quite a personal impact on me, inciting warnings not to engage too much in any form of ideological circles, which only gradually became comprehensible to me.

Certainly, this story is heavily related to my own history and my resulting perspective on this world. Yet at the same time, the above quotes make clear that the implementation of OD is linked to a powerful demarcation of an OD social identity (apparently also perceptible from the "outside" as well), leading to rigid outside-inside boundaries: following the described implementation process, the teams *"have been divided,"* whereas those who practice OD saw *"themselves as superior"* and "*everything else aside OD"* was described by them as being "*wrong or worth less,*" drawing a rather "*hard and fast line of what is allowed and what is not.*"

Thus, apparently a rather rigid social identity has been developed among those that had been trained in OD, for which I will use, for didactic reasons – with the intention to elicit strong reactions that often help to clarify arguments – the strong metaphor of a "sect." This social identity has led to the perception of an in-and outside of this group of trained professionals, leading to various questions such as: is the OD community a rather rigid community, binding us together in the form of an ideologically charged grouping, perhaps with strengthening our feelings of connectedness and solidarity, but certainly at a cost? Is such an inflexible grouping useful, given the difficulties that usually occur when a new intervention is implemented in the field of mental health care, or does it not rather make implementation processes more strenuous, thus being certainly of no interest to those that want to practice OD?

With this in mind, a huge number of further questions arise – some of which have also been discussed during a conference, at which the provocative question of "in how far does the OD community resemble a sect?" had been discussed vividly: is there one single OD community, and if so, who are "we"? Do we share certain intentions and what are our motivations? Even more, are we following a "mission," for instance to combat the medical system or to reform our society, and is there only one mission, or inversely, do we really allow for polyphony both within our community and in relation to the outside? Which (implicit) moral or ethical messages are we acting out when practicing or providing training in OD? And finally: is the OD approach, and are we, who practice or train people in it, as power reflexive as it/we claim(s) to be?

And further: given its principles, should the primary task of the OD approach not be to allow for a plurality and diversity of voices? Do not we make ourselves untrustworthy if we openly or implicitly devalue other mental health care practices or ways of thinking? What about the principle of multi-vocality in this case?

How can we allow for difference and open exchange between different approaches in the field of mental health care, without giving-up or watering down our own principles or achievements? Even more so as it increasingly seems to be difficult in this world to exchange views across different positions to create an understanding for each other. Self-contained perspectives or communities are not helpful in this context but may rather reinforce harmful identity politics.

At the same time, during this conference, it became clear that the image of a sect is a powerful one, thus also raising various concerns among the discussants: does this image lead to the OD approach being perceived to be less scientific? Does it foster a stereotype of the OD community as an entangled coterie, or does it lead to constructive discussions about its implicit or explicit exclusion mechanisms or power relationships? In short, does it do more harm in relation to OD training, implementation, or advocacy or does it rather lead to more transparency and a greater acceptance of this approach?

Katrin

I do not think there's anything wrong with having an ethic. And we are creating spaces together with others. These others are our fellow human beings and colleagues. So, we are a group, and this inevitably involves a social identity. Yet, right from the start, in trainings, we can engage in open dialogue, allowing for more polyphony. I think that is possible. We all have different experiences. That is a gift.

"Teaching means learning," a simple sentence. I think this means to respect and give space for everyone during the learning and teaching process, to enable multiple viewpoints as an antidote to power. Further, may learning the practice through the practice itself help to diminish power differentials? Almost the whole conference in Tornio took place in a dialogical way. In Finland, they have an outstandingly good school system also, in which dialogue is practiced and taught. I wonder if such a "flow-in-action" may be related to the traditions of the Finnish Sami people? As we all know, there are techniques, even for witchcraft. And what we call "witchcraft" – or a "sect" – might be a common, old practice between us humans: the urge to gather, share feelings, ideas, stories.

The past is the present: in each society, there seems to be an urge to normalize misdeeds, traumata, and violence. Collective memories, experiences that crisscross families, such as wars, institutionalized violence, child abuse, etc. (Psychiatric) institutions were part of these horrors. It feels to me that in German psychiatry, there is an unbroken tradition since the Nazi times. Not directly, but the much earlier death of the "mentally ill" (also due to treatment (Wunderink et al., 2013; Begemann et al., 2020)) seems to be widely accepted. Given this context, how can we implement OD without passing on or acting out power?

Maybe, these contextual understandings should be more reflected: should we open-up more spaces for these stories in the OD trainings and network meetings and also in society? A lot of people working in psychiatry have a lot to share. And if we teach and moderate and try to build up precious spaces (pedagogical flow? witchcraft?), we must ask ourselves whether we can bear these horrors done to our people, fellow travelers, or maybe to us. And we also must ask ourselves whether we project our understandable fears or feelings of these horrors onto others. To not feel the pain ourselves while working. Remaining simple and compassionate is a big thing. And small at the same time. All we can do. A small thing…

Katharina

The interview data makes one clear: listening to people who do not choose to use OD after being trained is vital to be able to learn how to pass it on successfully. One goal of OD is to empower people regardless of their position in a network, so the question of how power is perceived and dealt with during processes of OD implementation is a central one too.

I was surprised that OD trainers were perceived as "Knowing-it-all," because one of the OD principles is "tolerating uncertainty," which to me seems to be the opposite of being in a knowing position. In my understanding, while developing OD in Tornio, they did not introduce a set of principles to change a running service or to form a new one. Instead, a continuous self-reflective research approach was started. Thus, the methods of practice were continuously improved and powerful "us versus them" distinctions between practitioners were avoided. Further, I heard from Finnish teachers, that OD cannot be taught, but can only be learned. It is not about doing something to someone, but creating opportunities for curiosity, dialogue, learning, which the so called "student" can freely choose to make use of or not.

The part about threat to power relations particularly resonated with me. One reason why I value Open Dialogue is because of its different perception of who is in charge, seeing each network member as a living being who is responsible for their own process.

If we feel safe, we are more eager to try out new things and more able to access our prefrontal cortex (Porges, 2011). Notions of "power games" or "non-transparent motivation" may point to a lack of safe space during trainings or in work situations. Maybe certain preconditions that allow participants to show vulnerability or curiosity have not been fulfilled, which to me seems to be quite often the case in a medical and hierarchical environment where "the doctor is always right."

This hierarchical organization in hospitals may have detrimental consequences: If you have not been listened to or been devalued several times, you become careful and will no longer answer questions openly or expose your critical positions. For instance, I am thinking of nurses, psychologists, medical interns, or patients who traditionally were not supposed to question a doctor's decision. Being part of these powerful hierarchical relationships has even influenced me, a doctor that *via* her role usually is perceived as being on the rather sunny side of the

system's hierarchy, while I often did not feel powerful at all: from some colleagues' derogative comments about others, I feared that if I showed insecurity or doubt about my work, I would be talked about in a similar way. Even when I felt overwhelmed, I tried not to show it.

It took me years to allow myself to feel and express my pain and insecurity in certain situations – for example, about coercive measures I prescribed from lack of better alternatives in my context -and I am not yet finished with that issue either. Several group settings with colleagues both in OD and other contexts helped me to find my voice and agency. Only through this can I now learn to improve how I treat patients in these situations. Without that support, I would not have had the strength to further pursue my career or OD.

Discussion

From the above reflections, the question arises as to what can be done to reduce the power-related implementation obstacles described? One of the most frequent questions arising in discussion about the OD approach has to do with whether this approach is an intervention/method/technique, or rather – and thus seeing the issue as a simple, raw dichotomy – an attitude toward life/position/culture? What are the power-related consequences of each of these positions, when practicing, speaking about, or disseminating the OD approach? Are there any dangers or pitfalls if a practitioner decides in favor of one of them? To reflexively deal with power differentials, we advise the second option: thus, it may be good to remember that the OD approach makes use of a human being's abilities and need to think and act dialogically. OD is making use of this basic cultural practice, it makes attempts to create a space for it. Such a perception of OD may provide a more modest, less powerful, and simpler view of this approach: OD is nothing special but has reached out to enact a fundamental human practice that we all share if we (dare to) practice it.

At the same time, perceiving OD as a cultural practice could call into question the very notion of implementation: is it truly possible to "implement" Open Dialogue? Is "implementation" the right word when it comes to (re-?)learning or further developing the basic human ability of dialogically relating to each other (see also 10)? We all have experiences with (non-)dialogical interactions and conversations, within both our private and professional lives. Certainly, the mental health systems we work in usually do not provide for sufficient possibilities to practice dialogical forms of care. Even worse, current systems may require the opposite: to speak and act monologically. Is it the actual dialogue that needs to be "implemented" or should we instead create a favorable context so that dialogical work becomes possible – in the sense of enabling it – an environment that is certainly worthy of insisting we make happen? Focusing on the context rather than on the nature of a social group or belonging, the latter view may balance or reduce powerful processes of identity politics and, thus, contribute to a solution in dealing with them.

At the same time, insisting on creating such an enabling environment may have the potential too to result in power struggles, leading to the next possibility to constructively deal with power differentials, when implementing the OD approach: Even if psychiatry may have its own dogma, this does not entitle us to (ab)use OD to create a counter-ideology. Thus, we should be careful with disseminating unifying or unified messages. Instead, we should allow for the dialogue between different "versions" of OD, accept contradictions and ambivalences, as well deal openly with the risk of monological preaching or dissemination of this approach: critique of OD ideology could be included in trainings and enabling practices as an integral part that is always present. This is even more important in the case of "top-down" implementation (the boss wants OD, and the employees must implement it), thus opening-up the opposite question of how we can find better means to enable OD bottom-up?

Seen this way – and this may be a further way out of the described power struggles –, any forms of dialogical teaching, communicating, and disseminating the OD approach are helpful to prevent dogmatism in relation to the implementation of the OD approach. The perception of OD as a basic cultural practice provides us with a guiding image here, to be used in connection with related processes of training and dissemination. This is even more important as this approach raises fundamental questions in relation to psychiatry, entailing the danger of too certain, all-embracing, monological answers to human suffering and existence. Instead, how can we create dialogical, meaningful, open, and safe spaces for doubt and skepticism that at the same time make positive experiences with the OD approach accessible and understandable to others? How can we transfer and debate knowledge without becoming (overly) monological, or closing-down variance and difference?

While discussing our perspectives, a critical study on feminist women's groups of the 1970s came to our minds (Freeman, 1971): in the beginning, many of these groups avoided any leadership or directives for political reasons, with a devastating consequence: implicit power relations could expand and stabilize, often being more difficult to identify than authoritarian control. Thus, claiming "openness," "tolerance," or "polyphony" will not suffice to make power visible in OD spaces. Quite the contrary, these affirmations can be abused as effective weapons or invitations to powerfully occupy them. Thus, a continuous reflexivity appears necessary to better understand what emanates from us when we practice or enable OD, how we position ourselves in relation to our community/ies and toward "the" outside(s).

When discussed at the conference, the image of a "sect" seemed to dominate huge parts of its closing session, making clear how powerful it is, thereby foreclosing or reducing possibilities of alternate interpretations and investigation. Likewise, during the writing process, we recurrently wiggled with power issues, such as falling short of sufficiently reflecting on questions, such as: who sets the topic, who invites whom for which reflection, who is in editorial power, and whose contributions are adapted to which

scientific and academic contingencies? As a result, achieving a dialogue between each author through their contributions has not been easy. In this sense, even thinking and writing about power struggles may itself be fueled with power. But maybe, it is naïve to believe that human interaction would ever be free of interests and different ways of asserting interests. As if writing or speaking against power will make you run the risk of falling into its trap.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Author contributions

SP has developed the first draft. KS and KE have added their reflexions and ideas to the discussion section as well as revised the manuscript many times. All three authors have contributed to the draft of the attached manuscript. All authors contributed to the article and approved the submitted version.

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The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Dissonance as a productive force in the emergence of alternative crisis support and impetus for social change—principles and organizational form of the association Open Dialogue Leipzig e.V.

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Introduction: This article examines the productivity of dissonance in the development of alternative crisis intervention methods, using the German example of the "Open Dialogue Leipzige.V." The research provides detailed insights into the development of the association and the adaptation of the OD approach to local circumstances.

Methods: The presentation is based on a participatory research process, primarily processing interview data using the Grounded Theory Method. It analyzes the specific practices of implementing Open Dialogue within the association and the organizational and contextual conditions corresponding with it.

Results: Despite the challenges accompanying the introduction and sustainability of Open Dialogue in the German healthcare system, the organizational structure of the association—characterized by grassroots democratic principles and a community driven by a strong willingness to change—enables a successful application of Open Dialogue principles.

Discussion: The article critically illuminates how engagement, professionalization, and participatory learning mutually influence each other through the organizational form of the association, bringing forth an innovative crisis intervention that could potentially serve as a model for other contexts.

KEYWORDS

Open Dialogue, crisis intervention, participatory research, learning organization, alternative psychosocial practice, grassroots, democracy, grounded theory

1 Introduction

The Open Dialogue approach is a therapeutic approach and organizational philosophy that has been developed in Finland during the 1980s. By promoting egalitarian communication by involving service users and their networks during joint processes of understanding the problems of concern and decision-making, it aims at avoiding stigmatization and to rely significantly less on medication (Olson et al., 2014; Putman, 2022a,b). The Open Dialogue approach follows 7 basic principles: (Aaltonen et al., 2011; Seikkula et al., 2011): (1) Immediate help in crises, ideally within 24 h; (2)

involvement of the social network through network meetings from the beginning of the treatment; (3) flexibility and mobility with regards to the needs of the network in terms of frequency, location and participants of the network meetings; (4) responsibility for the organization and implementation of the entire treatment process by one and the same the treatment team; (5) ensuring the continuity of relationships and common understandings over the entire course of treatment; (6) tolerating uncertainty during the network meetings and (7) promoting dialogue and polyphony between network members as well as the members of staff. A more comprehensive description of the approach and of its evidence can be found elsewhere (Mosse et al., 2023).

In the German-speaking psychosocial and psychiatric care system, the implementation of the Open Dialogue (OD) approach is still in an exploratory stage also concerning its effectiveness and sustainability (Heumann et al., 2023).Thus, evidence of the effectiveness of this approach has primarily been demonstrated outside of Germany, various cohort studies providing promising results regarding clinical, economic, and social impacts (Seikkula et al., 2006; Aaltonen et al., 2011; Bergström et al., 2017, 2018). In contrast, the implementation of OD in Germany rather corresponds to a grassroots development, so far mainly driven by dedicated professional teams or individuals (Heumann et al., 2023). Among these are some bottom-up implementation approaches, which in some places also resulted from criticism of established power and care structures, a criticism that is inherent in the concept of OD (von Peter et al., 2021), often leading to challenges during implementing this approach (von Peter et al., 2022b). Thus, despite its high implementation frequency compared to the situation in international care systems, is not particularly pronounced, mainly resulting from contextual implementation barriers that widely impede the degree of implementation of OD-specific principles and features in Germany (Heumann et al., 2023).

Against this background, the question arises about alternative contextual and implementation conditions that would enable the introduction and implementation of OD in its full form in Germany and elsewhere. In this context, this manuscript focuses on a support project in Leipzig that facilitates the establishment of crisis intervention along the OD principles to a large extent. This work is part of a larger evaluation project of understanding the specific approaches to crisis intervention in the Leipzig initiative. This evaluation project was implemented in the form of two qualification theses of the first author and a student of psychology as well as collaboratively with some employees of this initiative. This manuscript presents the main results of the doctoral thesis involved and follows the research questions: (1) how did the path to implementing an alternative form of care in Leipzig unfold and how was it motivated? (2) In which ways the organizational form of this initiative corresponds with the OD approach more generally? (3) Which contextual and environmental conditions are offered by the Leipzig network that facilitate the implementation of the OD's specific principles? Thereby, this manuscript aims at describing the mutual interrelationships between the organizational context and the specific care approach as practiced in Leipzig to illustrate the various ways in which they influence each other in creating a favorable environment to implement the OD approach.

2 Materials und methods

2.1 The initiative in Leipzig

For further insights into the approach in Leipzig and a more detailed description of crisis support as it is practiced locally, we refer you to some relevant excerpts from the association's website in Supplementary Figure S3.

The initiative in Leipzig was founded as a formal association in 2017 with the aim of providing crisis intervention using the OD approach (Putman and Martindale, 2022). Emerging from a rather club-based and largely unfunded or minimally funded organizational structure, a challenging development process started. The beginning of this process was characterized by improvised solutions in sparsely furnished rooms, highlighting clear differences from the contextual conditions of usual professional institutions. Motivated by shared dissatisfactions with the principles and practices of conventional psychiatric care models and a strong desire for change, the group of initiators opted for OD as the central therapeutic approach. This decision led to the establishment of a suitable location and the gradual unfolding of the working practice described below.

The association first emerged from a circle of friends—a circumstance that no professional psychiatric or psychosocial service may claim as its origin. In the following years, new employees joined through contacts during the network meetings, initially working as freelancers, which in some cases evolved into permanent employment. Conversely, there are also former employees who remain connected to the association but only contribute on a freelance and occasional basis.

In the early years of the organization, new employees often started without OD training or a solid understanding of this approach. Such 'learning by doing' no longer occurs in this form: a thorough theoretical engagement with this approach as a minimal consensus soon after starting one's work, followed by taking part in an established OD training, is the currently preferred path to a qualified participation in the crisis intervention program in Leipzig. In addition to outreach crisis interventions, the association also offers group support, open counseling sessions, and counseling in the sense of independent participation counseling.[1]

From the outset, peer work has played a central role in Leipzig, as also practiced elsewhere in the context of OD oriented services (Bellingham et al., 2018). Thus, a mix of various experiences are drawn upon when supporting people in crisis, involving the experiential expertise of being either a service user, and/or a family member, or a professional support worker, whereas formal-technical forms of knowledge are rather relegated to the background (von Peter et al., 2022a). In addition, people and groups of people external to the initiative in Leipzig use this context to pursue their own concerns and interests, bringing in various ideas and projects that complement the services of the main group of employees. Thus, the community of people present in the Leipzig initiative is variable: permanent and freelance employees, users, guests, interns, and researchers. In the following, all these people are summarized under the term "association."

The work of the association does not fit into the conditions of the usual funding system for various reasons to be explained below. Thus, over the years, financial resources had to be found to finance the support work in Leipzig at least partially. The long list of sponsors includes the Health Department of the City of Leipzig, various NGOs and business support programs, foundations, and private donors. In addition, employees were organized through voluntary services, and

1 https://www.teilhabeberatung.de/

the association collects membership fees. Currently, discussions with the psychiatry coordinator of Leipzig and the local mental health board are underway exploring possibilities of sustained funding. While the association in its early years felt little taken seriously and encountered reservations and ignorance in Leipzig, the situation seems to be changing currently. For example, a team from Leipzig University Hospital participated in OD training and subsequently worked with this approach in the context of a home treatment program. At the same time, the question is repeatedly discussed as to whether and to what extent regular funding changes the character of the service and restricts freedom in the exercise of one's own OD practices.

The work in Leipzig is organized as a grassroot democratic form, devoting a high commitment of resources to internal communication and supervision. The ability to work productively in such team structures has become a significant criterion for employing new staff. Interactive learning of the employees has proven to be a central aspect, with both the use of competencies from previous qualifications and the discussion of the implications of this professionalization being repeatedly debated. Collaborations beyond local networks are lived out, including national and international partnerships, embedding the association in a larger context, and providing support and intellectual exchange. These aspects, as well as close collaboration within local Leipzig communities, offer promising conditions for authentically living out the principles of OD, as this work aims to demonstrate.

The employees usually document the crisis intervention work by collecting only sparingly relevant data. For the year 2020, this data was analyzed using descriptive statistics. It emerged that over this period, a total of 425 network conversations were held. Requests for crisis intervention came from networks or individuals, with users/index clients usually contacting first, followed by family members and professionals. In the period of crisis intervention considered, it was possible to involve more than one person in the dialogical meetings in about 43% of the conversations.

Further information on the association Offener Dialog Leipzig e.V. is assembled in Supplementary Figure S3.

2.2 The research context

The impetus for the evaluation project came from the association itself. Due to the lack of financial resources, it was decided to conduct the research as part of two qualification theses, one master's and one doctoral thesis. The position for the doctoral thesis was advertised by a research group at the Brandenburg Medical School, which had already been involved in research on OD (von Peter et al., 2020, 2022a,b; Heumann et al., 2023).

2.2.1 Research approach

Taken these collaborating partners, the project is positioned in between a collaborative (von Peter, 2017) and a community-based participatory research approach (Engage for Equity, 2023; Allweiss et al., 2024). The research team and the research members of the association were involved as partners throughout the research process, from developing the research question, through data collection and analysis, to coordinating publications. Such an approach is based on mutual learning and transparent communication, helping to align scientific investigations with the needs and priorities of the people in the research field (Unger, 2014; Wallerstein, 2018; Ackermann and Robin, 2022).

2.2.2 Research participants and practice partners

This work is part of the first author's doctoral project. Together with the last author and the master's student of psychology, he formed the core research team (TK, JÖ, SvP), being able to contribute the most significant temporal resources for the undertaking of this research. Thereby, TK participated in all research meetings, interviews, and collaborative procedures of analysis. Additionally, he undertook a short period of participant observation, providing an excellent opportunity to deepen his understanding of the specific approach in Leipzig.

Additionally, up to five co-researchers from the Leipzig association participated in the process, contributing intensively but variably throughout the process. These individuals are as follows: LGC, TKru, IN-H, these individuals are referred to as "practice partners" (= PP) following the nomenclature of the German-speaking Network for Participative Health Research (Schaefer et al., 2022) throughout the following text.

The persons who consented to participate in the study and took part in interviews are referred to in the following as "research participants" (= RP). We contacted users of the services in Leipzig and team members, respectively, to inquire about their experiences with this support work. For reasons of data economy and following a decision in the research team, only little socio-demographic data was collected from the participants. A brief characterization of the sample can be found in Supplementary Figure S2.

2.2.3 Development of study materials

During the first constitutive meeting of the research group, interesting aspects were collected, and a common thematic focus was developed. From the association's side, there was interest in presenting and evaluating their own work with the aim of a better self-understanding and to communicate this understanding to outsiders. From the academic side, there was interest in the unique form of implementation of the OD approach and how this relates to the specific organizational form of the association. Relevant questions were collected within the team and used for constructing two interview guides (Helfferich, 2011). The interviews with the users of the service focused on their experiences and evaluations of the crisis intervention in Leipzig. During the interviews with the association's employees, the focus was on organizational aspects. The key questions of the interviews are summarized in Table 1.

2.2.4 Case selection and recruitment

Service users were asked for an interview using a contact list of the association's network. This task was undertaken by interns of the association who were not part of the research team. In addition, a flyer was created introducing the research and distributed in various places in Leipzig. Regarding the team members to be interviewed, the PP facilitated contact with individuals who indicated a willingness to participate. Additionally, all current and former active team members were approached.

In both groups, all individuals who expressed willingness were interviewed. As indicated in Table 2, especially the team members were ready to participate. The people who declined to give an

TABLE 1 Key questions of the interviews.

Interviews with service users	Interviews with team members
1. In which situations did you come into contact with the Leipzig Initiative?	1. How did you come to the association and to work in this Initiative?
2. What expectations did you have when you first contacted this Initiative?	2. How is the Open Dialogue organized in the Leipzig association?
3. How did you experience the support work?	3. How did you organize yourselves as a group and your work?
4. How did this support work change you situation?	4. What do you think is special about the Open Dialogue in Leipzig?
	5. How do you like your work and what do you wish for the future?

TABLE 2 Selection of participants during the recruitment process.

Group	Service users	Team members
Attempt to get into contact	76	16
Successfully contacted	57	16
Willing to participate	22	13
Excluded	3	–

interview had various reasons for not doing so: uncertainty about the topics to be discussed; belief that they could not contribute anything relevant; discomfort in talking about sensitive topics; fear of renewed emotional stress; low confidence in research. Three interviews with users were removed from the data set. The decision was made by the team after it became clear that the work in these networks followed different procedures than Open Dialogue.

There was no selection by the research team or any formalized sample principles. The search for individual cases with a special focus, in terms of theoretical sampling of Grounded Theory Methodology, occurred in the research process through two methods: first, by selection from the existing material, and second by shifting the focus of the interviews alongside the data obtained.

2.2.5 Interview conduct

Using the developed interview guides, 32 semi-structured interviews were conducted with 13 team members and 22 service users, audio-recorded, and transcribed. The interviews took place in the association's premises, at home, or in other locations, either in person or online/over the phone. They were conducted by one PP researcher and two academic researchers, with a smaller proportion of conversations with users also conducted in tandem. Conducting interviews in tandem proved to be very beneficial for collecting rich data, as the perspectives and focus of the questions complemented each other, leading to more diversity during the conversation. The transcription of most of the interviews was undertaken by research assistants and a professional service, while some were transcribed by the master's student himself.

2.2.6 Analysis

Grounded Theory Methodology was chosen for the analysis with the aim of developing a middle-range implementation theory. Qualitative data are generated and interpreted using this approach through continuous iteration of collecting, coding, and analysis to develop a theory rooted in the data. This method has been described as suitable for participatory research processes because it allows for an open and flexible approach (Charmaz, 2015).

In the project described here, a specific methodology was developed for coding the material, which can be used for both collaborative coding and individual work. This method has been extensively described elsewhere and compared with similar working methods (Klatt et al., 2025, in preparation). At this point, the coding process will be briefly described: The analysts first familiarized themselves with the material through reading or listening. Primary coding was done individually and case-specifically. For most of the material, the analysis was conducted individually, with some interviews analyzed collaboratively in tandem (one person of the research team, one PP researcher). This second working mode occurred as follows: After primary coding, the individuals involved met over several sessions to discuss and consent to categories (step a). In the second step, the focus was on 4–6 codes, which captured the essence and specificity of the text from the researchers' perspective. This step was initially done individually (step b). Next, there was an interpersonal comparison of categories, aiming to merge similar categories and leave disparate ones. Again, the tandem selected 4–6 categories that informed the overall analysis (step c). When inserting the results into the overall project in the MAXQDA software, the consented descriptions and definitions of the codes were used to find suitable anchor examples in the source material beyond the case and connect them with the codes. This feedback served as validation of the codes and to establishing a close relationship with the primary data.

In this way, individual analysis cases were added, and the overall analysis progressed. Interim results and initial theoretical derivations were presented and discussed in research group meetings with all PP. In the final part of the analysis, theorizing was the last step of our proceeding. This theoretization of the material was undertaken by engaging with the empirical material from the interviews and various theoretical concepts that were selected to make sense of them, from both the background of OD and other theoretical fields, such as dissonance (Festinger, 2020), (de)professionalization (Grey, 2019), community of practice (Wenger-Trayner and Wenger-Trayner, 2025), translational learning (Tsimane and Downing, 2020), peer work (Bellingham et al., 2018), etc. These theoretical sources relate to the context examined in Leipzig and are the first building blocks of a 'Grounded Theory' of local implementation conditions. Due to the lack of resources, this theoretical work was limited in its duration, as well as its empirical grounding. Thus, further interviews or focus groups to communicatively validate the theoretical model were not possible.

2.2.7 Ethical considerations

Although the participatory research approach combined with an open methodological approach sets a framework that aims for a relatively balanced relationship between researchers and participants, we are nevertheless operating in a vulnerable field in which power and dependencies play a role. Therefore, all kinds of participants were informed of their right to withdraw from the study at any time without consequences. A further requirement was that people and networks currently receiving crisis counselling were not asked to participate.

Ethical research advice and a vote were obtained from the Ethics Committee of the Brandenburg Medical School.

3 Results

The results presented below are a part of the developed Grounded Theory. They are divided into two main parts, which are logically connected: to answer the research questions 1 and 2, the first part presents statements from the participants (=RP) that illustrate their experiences with the conventional psychosocial/ psychiatric care systems (Section 3.1). The development of a unique way of working and organizing the support work in the Leipzig association is described in the second part as a result of these experiences (Section 3.2). An overview of these topics is given in Table 3.

Finally, and alongside the research question 3, the support practices in Leipzig were reviewed in relation to their fidelity to the OD principles in Section 3.3 (Olson et al., 2014). Since any implementation of fidelity principles is of little importance if not experienced by service users, this evaluation of fidelity is carried out from the users' point of view (perceived grade of OD fidelity). Due to the length of the article, the results of this evaluation section is only presented in a tabular format.

3.1 Discomfort in relation to the system

Both service users and association members contributed closely related perspectives on this topic, stating that everyone is affected by the care system in some way. Individuals with an academic background reported on psychological teachings at universities (e.g., biased in scientific and treatment concepts and methods, thereby constraining ways to think differently), which cannot be listed here due to space constraints. All these topics and gaps described became the starting point for personal suffering, leading to the impulse for change by establishing the association and/or participating therein.

3.1.1 Unwelcoming care

The processes and structures of the psychosocial or psychiatric treatment facilities were perceived as unwelcoming. This closeness appears as a logical consequence of the prevailing medical paradigm:

> "I think such resignation also comes from the fact that, I do not know, this ward is not such an inviting place. I was there recently and was allowed in. It was like a hospital ward with neon tubes on the ceiling, a dark corridor. I would wish my sister to be able to leave there as soon as possible." (P17N 90, service user)

At these places, service users do not feel well heard and understood. Situations of crises were classified using diagnoses, whereas different perceptions and subtle tones often go unheard or succumb to the pressure of high workloads. The clinical areas were described by the participants as characterized by hierarchies and power structures. Association members recalled their clinical experience as marked by regulations:

> "I had just done an internship in child and adolescent psychiatry, and that was typical clinical routine, very hierarchical. I had a conflict because I did not address the head psychologist formally. That was a topic for several weeks, it felt like, and very structured hospital routine, many meetings, case discussions, many post-discussions within the teams only. Little contact with the patients." (P9M 14, association member)

Further, instances of exercising power and coercion were well described.

3.1.2 Lack of support

Lack of support appeared primarily to be a qualitative problem. There were rejections to support users in acute crisis, referrals, and waiting times that were not compatible with these situations. Difficulties arose when the needs of individuals go beyond what is offered:

> "…you just cannot forcibly through-out someone from their apartment because they have cluttered and dirtied everything.

TABLE 3 Themes and subthemes of the analysis.

Discomfort in relation to the system	A specific form of organization	The shape of the association's work from the service user's perspective
Unwelcoming care	The formation of the Leipzig association	Network culture
Lack of support	Young employees at the beginning of their Professional careers	Peer involvement
Lack of network-perspective	Group development	Alternative culture
Painful treatment histories	Networks	
Illness-causing conditions	Participation	
	Culture of welcome	
	Alternative culture	
	Mutual learning	

> And then send them to psychiatry, not caring at all about the state of their apartment, and then release them back into that shitty apartment, in the truest sense of this word." (P1M 150, association member)

Social work and discharge management in clinical departments were perceived as inadequate. The life situation of the affected person beyond the clinical situation was too little considered. In some cases, hospitalization was the result of a lack of outpatient support:

> "You cannot have anyone come to the house. Only the police. And that somehow does not work. So, it's really difficult. It's like waiting for an escalation or something, which is very terrible and which burdens everyone a lot. And, actually, this only exacerbates the whole situation and, I think, even creates it." (P8M 73, association member)

Individuals and their networks were not well-supported during very stressful situations up to the point when it was no longer possible, and hospital treatment remained as the last option. When it came to workplace reintegration, further, service users complained about a functional orientation of assistance: those deemed unsuitable for the labor market and not dangerous to the environment gave institutions little incentive for intensive support.

3.1.3 Lack of network-perspective

OD means working in networks—social and professional. In the conventional care system, the participants of our study experienced contradictory tendencies:

> "…the parents are perceived to be annoying when they come and will then be sent away. There are many reservations about networks; friends are not even talked to or anything." (P1M 162, association member)

Family members were reported to have easier access. But if the network extended beyond the usual family circle, barriers became greater:

> "However, I actually went to such a family counseling center, and they said, 'maximum two people.'" (laughs). (P3M 42, association member)

At this point, a clear difference on a paradigmatic level between widely practiced psychiatric practices and network-oriented work became apparent.

3.1.4 Painful treatment histories

The painful experiences from the perspectives of the users were manifold. Often, the initial contact was already perceived as a traumatizing situation in which trust is shaken or cannot be established again:

> "Yes, I would like to speak to someone," "Yes, someone will come down soon." That was exactly the person who called the police. And I was supposed to complain to that person […] That was quite intense. (P8N 7, user)

The way of treatment brought new problems to the users: communication failures, hospitalization and treatment with psychotropic drugs that bring side effects, application of coercion etc. Even if the treatment seemed to be ineffective, service users found it difficult to break away from it:

> "Because I thought, there are also people who fight so hard to get out of there. And who still end up in the system again and again." (P5M 86, association member)

The abundantly described painful treatment histories led to the rejection of current care and the search for alternative approaches.

3.1.5 Illness-causing conditions

This approach to people in crisis was also found by the participants of our study to be largely accepted by society as normal. An excessive demand to perform weighs heavily on individuals who cannot meet these demands or fear doing so:

> "You probably know the term 'normopath'?" (P9N 13, user)

Some people cope well with this socialization and can function, others cannot. The research made it clear how deeply people were disturbed by the day-to-day pressures they experience:

> "The working load, that's why many have these diseases. Because it's empty of meaning, the pressure is too great. What's all this crap for, yeah?" (P9N 80, user)

The critical view of social conditions were addressed throughout the material. This critical, continually questioning attitude emerged as a commonality in both groups:

> "So, a very critical and vigilant view, I think, of the classic model that exist. That's what unites us. How is the UN-CRPD implemented? Or how are people in crisis situations, for example, dealt with? So why is it so difficult to find therapy places? Why is admission or the clinic – why is that often the answer? Why are medications often the answer?" (P10M 42, association member)

It was therefore about the relationship of the individuals in the association to the common system of psychosocial care, embedded in an overall societal system.

3.2 A specific form of organization

The following statements refer to the specific organizational form of the association in Leipzig. The description of the organizational form, as expected, has been derived more from the statements of the participating staff. Users primarily see the practice of crisis support, and the organizational form is not always clear to them. Accordingly,

in the following sections, the quoted voices mostly stem from the association members assessed.

3.2.1 The formation of the Leipzig association

The formation of the organization in Leipzig, as described above, originated from a circle of friends, which raised the question of the further development path seven years later in the history of the association: do employees still connect through the association's work as friends?

> "I sometimes have this need to involve people I know. Then I ask them if they would like to contribute as volunteers in our structures of crisis support." (Int2M, 90, association member)

Beyond the group of people who worked more or less directly within the project, there was a veritable "scene," in which information was circulating:

> "We have a wide circle of friends, and that spread quickly in the psychiatric scene." (Int2M, 26, association member)

The exchange of information in this circle seemed to be a difficult-to-control process.

3.2.2 Young employees at the beginning of their professional careers

All employees who took part in interviews were young with an average age under 30 years. Further, during the research meetings, it became clear that there had not yet been any notable exceptions form this staffing in Leipzig. Most of the employees started working in the association immediately after completing their studies. A few had previously worked in other areas, as well within the conventional system of psychiatric care, which, however, was rather considered to be an obstacle to their job in Leipzig:

> Before that, I had worked in assisted living as a caregiver. In a residential group of outpatient assisted living. In the moment, I'm an occupational therapist… But I try to forget that. Well, I kind of have to forget that to be able to work well here. Or a lot of it. (I3M, pos. 8, association member)

When the interviews talked about professionalization and its significance in the current field of work, it became apparent that the rather open constructions of professional regularly became a problem regarding financial opportunities:

> With every funding application, some kinds of qualification are required by the funding institution: staff is supposed to be psychologist, or social pedagogue etc. In any case, each person must have a paper with some kind of stamp. It's just not enough to say: "there's someone who is in top shape to do this work." In principle, the cat bites its tail at some point: as soon as you start saying: "can you pay us for our work?," many people say in a friendly way: "yes, but only if you are psychologists…" Yes, but our concept says that we do not want this dependency on formal professionalization. (I7M, pos. 65, association member)

The group within the association was dynamic and open with various interfaces to the outside. Critical concerns with the conventional care systems seemed to be a crucial criterion for how the engagement of individuals was motivated (see above):

> "It's difficult to find people who see themselves affected enough to want to be involved." (Int3M, 114, association member)

One employee appreciated the exchange within the association both among the team and with the people who seeked their help, emphasizing the positive encounters that arose from it:

> "The best thing is the relationships within the team and with the people who request our help. There are so many beautiful encounters." (Int5M, 167, association member)

The difference from the usual ways, in which teams come together was that friendships existed partially beforehand, only then followed by joint work.

3.2.3 Networks

Networks could be families with experience in crises and their management. This experience was sometimes based on a long time of living together: as with other health problems, family members can become experts and bring their valuable knowledge into the work together. Employees became part of the existing social network during the support and offered relief for strenuous and long-endured situations of mutual concern:

> "I once noticed that the family being there is also security. Because they also deal with these problems all the time." (Int2M 50, association member)

In the following quote, the employee formulated a unique feature of crisis support using the OD approach: networks are the central resource for this work: the (family) system is not only the target of therapy, as in conventional approaches, but the very matrix of engagement and development to achieve change and improvement:

> "The fact that we involve the networks so naturally. I think that's already special. So not just: 'We have to coordinate.' but really doing crisis work in the networks." (Int2M 114, association member)

3.2.4 Participation

How did individual actions and network activities relate to each other? The employees in Leipzig tended to vary in their degree of integration into the team. Their previous life and professional experiences had an impact on their work in the association. What had been learned theoretically or from previous employment, however, at times needed to be unlearned to find one's way into this new form of practice:

> "To keep falling flat on your face and realizing, 'Oh crap, I did it again on my own.' does not work, in open dialogue, it does not work. You're always in pairs." (Int2M, 128, association member)

There were plenty of opportunities for involvement in Leipzig, the organizational structure largely based on a participatory way of working. Participation could be a welcome offer for all kind of people: for members of mental health care or private networks, other

professionals, or even private acquaintances. Interested individuals arrived at the association via these ways and could have become eventually permanent employees:

> "What was missing in my life was someone saying, 'there's a project, and you can join in.' To condition to join is that you do an interview beforehand to speak freely and don't omit certain statements. And then we have a project here, in which you can participate." (Int8N, 52, user)

At the same time, there were some hurdles to such flexible participation, such as participating in training: it seemed necessary to separate crisis support and general engagement in other areas of the association. Even in other areas of the association's work, access became somewhat more difficult in recent years due to development: the team grew and became more structured. Usually, a specific occasion was necessary for people to participate at all and to use the spaces offered continuously. This was a surprising finding considering the evidence that spoke for a successful culture of welcome in the association in Leipzig, a topic that will be thematized in the following section.

3.2.5 Culture of welcome

Employees warmly welcomed users and created an open atmosphere in which they quickly felt integrated:

> "And I was received as if I had always been there. The friendliness, the openness of the people who greeted me. And that was a relief for me because I'm not used to that." (Int5N, 16, user)

Users could be themselves in the association without having to pretend anything. Emphasis was placed on authenticity, and everyone was accepted for what they are:

> "You are free there and can be yourself. You do not need to pretend. You do not need to be afraid. This fear of many mentally ill people is not necessary." (Int5N, 22, user)

The openness and inclusivity of the group were clearly recognizable. Friends, family members, and the entire social network were welcome. The association served as a safety net and offered support:

> "Yes, meeting people is like nutrition, right? Encounters with people can be annoying or exhausting. But ultimately, that's better than not having any encounters at all, right? It's like brushing your teeth or something during those phases when things are spiraling downward, right?" (Int9N, 35, user)

The association enabled users to open and find support in a safe environment. The resulting bonds and relationships were of great importance to those involved.

3.2.6 Alternative culture

Joint rejection of certain conventions brought the feeling of being in the right place:

> "And that was always sympathetic, the right people who understand you. That's such an important point when you have a psychologist from an alternative background, as when a psychologist says, 'by the time you are in your mid-30s, is not it may be time for a wife and children? I just wasn't in the right place for that." (Int10N, 97, user)

"Alternative structures" with uncertain financing became familiar when individuals themselves had been activist in such structures in the past:

> "I am very familiar with this system based on donations and alternative structures, it feels at home." (Int10N, 97, user)

3.2.7 Mutual learning

> "There's no strict separation: 'we are the ones who understand, and you still have to understand it.' I'll put it in black and white." (Int8N, 35, user)

Learning was a genuine dialogical practice for all participants. Individuals remained experts in their life worlds and were to be addressed as such.

External groups with their own themes and situations also became aware of this principle and used the association's facilities and network for their services, thereby also developing the OD crisis support further:

> "Over the years, people came to set up support systems for pansexuality or others. Friend circles, yes. Mutual support systems combined with house projects to jointly live-in, that sort of thing." (Int2M, 26, association member)

The association became effective when its members knew what competencies were available and how they were distributed. Specific groups or individuals were contacted who were likely to provide good support in specific situations:

> "And then I also send people into the groups, of which I know that they have experience with tapering off medications and so on." (Int2M, 62, association member)

Several instances could be used for learning processes within the team: team meetings, intervision, supervision, team dialogue, OD training, and contact with external networks that supported or already practiced the concept. Lastly, learning took place during the support itself, during the network meetings. Two components were conducive to this process: there were always two moderators, and this practice remained consistently dialogical.

3.2.8 Perceptions of the service users

The significance of networks during the crisis supports in Leipzig was frequently addressed also in interviews with the users of these support services, either as something that had shaped their relationships before accessing these services or because of this engagement. Peer involvement in networks and among employees was perceived as a difference from conventional care. Further, it

became evident from the perceptions of the users that the basic principles of the OD approach could have far-reaching effects on their lives and how they experienced support during crises.

3.2.9 Network culture

The interview statements provided by users shed light on various aspects of a network culture and its various influence on dealing with crises. Their perceptions on this topic were multifaceted and differentiated. Some participants simply appreciated the principle of a network culture to be a central component of OD and central to their processes of recovery.

Another participant offered a fresh definition of such a network-focus, conceptually embedding the network meetings within everyday life routines—a definition that may also reflect the special organizational features of the Leipzig association:

> "I believe these networks need a new designation. Not psychotherapy, just a meeting of people, voluntarily. That's a different matter." (IntN11, Pos. 247, user)

Other participants underscored the inclusivity and equality they experienced within the network meetings as practiced in the Leipzig association: they felt part of the group and reported that open and unbiased dialogue with other people led to further conversations and new forms of relationships:

> "How to say it? As open dialogue is so open, many people just come into contact with other people, or become aware of them, through other people. Because they have noticed that this person has also experienced something, or whatever. And then conversations arise where I never thought, where I never thought, I would eventually be able to talk to about." (IntN5, Pos. 92, user)

After trying various solutions and their failure, also within the conventional system, users came to appreciate networking practices as a central for resolving difficult situations, by also shifting the attention away from their own problems and life situation:

> "And this developed into a direction that he also wanted, that it wasn't just about him, but that he also wanted to know how we as a group could support each other. And not just: How can we help HIM, but how can we all better relate, as a group." (IntNP01, 13, user)

These experiences led to various learning effects that networks could also be a resource for dealing with difficult life situations, and to be actively sought again when needed.

3.2.10 Peer involvement

In the context of the association in Leipzig, various aspects in relation to the perception of peer support emerged from the data. On a more general level, the widespread understanding was shared that peers share the experience of mental health problems, which was described to be supportive:

> "And I generally felt understood there because I felt that the people definitely also struggle with mental crises or have had them, maybe in the past." (IntN1, Pos. 112, user)

This led to a sense of connection and the opportunity for mutual learning, values that were also reflected in the organizational form of the Leipzig association:

> "I can remember that there was someone who described their voices, and I thought to myself, wow, I've never heard it like that before. That was fascinating and I think that's when I got a much better understanding of how it works with voices." (IntN5, 78, user)

This exchange with peer workers was described to be another form of interaction oriented towards supportive exchange and mutual respect, both perceived to be fundamental to the principle of OD as well as this approach was practiced in Leipzig.

In addition, the peers were also considered "similar people," suggesting that users did not see any categorical difference to the other employees and to themselves:

> "So where I say, 'These are similar people, they are talking to me and I'm that person.'" yes? (IntN9, 3, user)

The phrase "similar people" is theoretically interesting. It refers to closeness, which remains indeterminate, but indicates a special connection:

> "I've actually never met people who try to fight against the psychiatric system and in general. And then I got the flyer about the open dialogue and I got to know many, many people through it. These are all people who want to go against the system. I always had the feeling that I was alone in this. And they have always tried to silence me, especially the psychiatric system." (IntN5, item 94, user)

In this last quote, the shared feelings of dissonance appeared also in the perception of a user, also making clear that a "peer" was less understood as a support staff with lived experiences but more as a person to connect with due to shared criticism.

3.2.11 Alternative culture: critical at a distance from the conventional system

Most users proved to be informed about the alternative positioning in Leipzig and the theoretical foundations underlying this form of support:

> "Yes, it's a more anti-psychiatric association that's independent and, um, eh, yes. There is also a library with critical books. Of course, there are different ways of thinking and models. For example, I also know the socialist patients' collective." (IntN9, 51, user)

The association was perceived by all their users as a service outside the psychiatric care system:

> "… this place is basically an anti-pole to what is understood as social normality or something like that. This requires the willingness to negotiate and to show solidarity. And that the open dialogue gives everyone the option of receiving support. This is something very special, which I very much hope that in the future

> there will perhaps be more such positions and more people who do such work." (IntN15, 70, user)

The differences were seen in the type of interaction compared to those in usual therapy contexts:

> "I mean, they treat everyone who comes here as they are. You are an individual. And that's what they are there. You're not a case number, you do not have a diagnosis." (IntN5, 107, user)

A decisive factor here was also the political positioning of the team, which does not exist in this clarity in other support systems:

> "I'll try to describe it: suppose I had met people here who are all center- or center-right or conservative and had a very archaic idea of relationships between practitioners and patients. Or between what must happen now so, for instance, I can participate better in society, then that would not have worked. Then I would not have come back, I think, because I already have enough of that elsewhere, of such pigeonholing." (IntN18, 56. user)

3.3 Perceived grade of OD fidelity

As described above, the support practices in Leipzig can only be reviewed cursorily in relation to their fidelity to the OD criteria for reasons of space. Since, as shown in the discussion, the implementation of the OD in Germany is primarily lacking in fidelity to the structural principles (Heumann et al., 2023), in the following, the degree of implementation of these principles is focused upon from the perspective of service users. Further information on this and the implementation of the therapeutic principles can be found in Table 4.

The *network orientation* has already been mentioned above and was strongly seen in the foreground by the users of the support services in Leipzig. *Immediate help* was common in Leipzig too. In the interviews, users were surprised by the promptness of support they received:

> "… I had a crisis, and it happened very quickly; a colleague and someone else came directly and I was really able to express everything that was in me. That was really good." (I10N63, user)

The frequent use of contemporary communication media was described contribute to this low-threshold approach:

> "Modern media were used to clarify my issues relatively quickly. You do not have to reach someone on the phone during office hours, but you get an SMS or a Telegram message. This makes the whole thing easier." (IntN18, 94, user)

Good structural solutions have been found in Leipzig also for the implementation of *flexible and continuous* support: these principles were reflected in many facets in the descriptions of the user participants of our study. The location of support and the mindset of the staff involved were largely perceived to be flexible and continuously available without too many pre-fixed schedules or assumptions. Flexibility was appreciated in the conduct of the network meetings, leading to a rather radical acceptance of the specific needs and conditions of the participants. This also applied to the principle of *responsibility:*

> "Yes, definitely. I think that's what it was all about, this taking responsibility and thinking along with you, always thinking along with a person." (IntN16, 84, user)

Thereby, the taking-over of responsibility in Leipzig remained dynamic and was negotiated again and again during the network meetings. It was dealt with in the network, their participants assessing it together and deciding how they will distribute it. A high degree of *tolerance for uncertainty* (see citation in Table 1) supported these processes and saved energy that users often must spend on strategic behavior in relation to these questions in the psychiatric system. And finally, a high degree of fidelity to the principle *of dialogue and polyphony* played a role here:

> "Support was usually at eye level, which created a very positive atmosphere for me, even if the conversations were sometimes exhausting due to their degree of negotiation. But people came together to solve a problem together." (IntN18, 18, user)

4 Discussion

This manuscript presents the results of a participatory evaluation, in which the specific OD implementation practices within the context of an association in Leipzig were investigated using a Grounded Theory Methodology. During theory development, three theses emerged from the data, which will be discussed below. As mentioned above, these theses are not to be understood as a fully developed middle range theory, mainly due to a lack of resources, as described above. Thus, some terms and concepts that have emerged during the analysis were further systematized into three theses, providing for an initial theoretical frame to conceptualize the support work in Leipzig that will be further condensed in the concluding section:

1. Experiences with the mental health care system motivate committed professionals and peer support workers in Leipzig to turn away from it and to seek alternatives; these experiences facilitate the implementation of the specific form of practicing OD in Leipzig in an organizational form that currently is situated outside the system.
2. The association in Leipzig provides favorable conditions for the implementation and development of the OD approach, enabling opportunities for interactive and transformative learning that allow young professionals at the beginning of their careers to experiment; the association exhibits characteristics of a learning organization that provides fertile grounds for innovation in the field of mental health care.
3. The specific form of implementation of OD in Leipzig could serve as an example for similar processes in other environments in Germany and possibly internationally.

These theses will be discussed in the following discussion section against the broader background of implementation difficulties of the OD approach in Germany and internationally. We will address questions such as how the activities of the Leipzig network fit into this

TABLE 4 Anchor citations that demonstrate the perceived fidelity to the OD principles in the Leipzig support system from the point of users.

	Key elements	Anchor citations/ quotes from the material
1	Two (or More) Therapists in the Team Meeting	"We also had conversations together… there were network dialogues with a doctor and I one or two further staff." (IntN2, 111)
2	Participation of Family and Network	"I cannot say much about what OD means but in my memory, I think it was something like: Aha, here you are, here are four new people, one person who is sometimes not doing well and three people from her family…and then the conversation started." (IntN17, 44)
3	Using Open-Ended Questions	"…questions, such as: "tell me, what's going on with your day, how are you, what's going on with you feelings"? And I think that opens-up a lot, a lot of space." (IntN17 44, user)
4	Responding To Clients' Utterances	"And you could also say: 'I have to get out because of my emotions.'", then that was okay too. Or I could sit and we did not talk at all. But just sat there. You can also have a conversation without having to say anything." (IntN5 46, user)
5	Emphasizing the Present Moment	"I cannot pin it down to certain days as there was always something that touched me at every meeting. Emotionally, positively too. Because at that moment it was also shown that I cannot really be that crazy. That I'm just a normal person, a grown woman who has, or had, a lot of grief and worries. And not as someone sitting there who has a roof damage." (IntN5 86, user)
6	Eliciting Multiple Viewpoints	Outer: "That was the first thing I offered, because I'm very much in favor of people knowing each other and that they can exchange information. That's how to compare points of view." (IntN8 25, user) Inner: "First, I had to bring it up again and make it aware and clear and then also answer questions and look at it from other angles." (IntNP02 52, user)
7	Use of a Relational Focus in the Dialogue	Well, I think that helped us to understand each other a bit better during this crisis. I would say that the day after plus a few more hours was always quite harmonious until there was another crash somehow. But it was definitely very helpful to be able to somehow understand the other person's perspective. (IntN16 60, user)
8	Responding to Problem Discourse or Behavior in a Matter-of-Fact Style and Attentive to Meanings	"I could talk uninhibited. That's new me. Somehow, I was never very good at talking to the staff in the clinics. As absurd as it is, I wasn't looked at strangely. I noticed very quickly that I could simply tell the most absurd things without noticing the reaction. So, I was taken seriously with it, it was addressed, although we were all somehow aware that it had nothing to do with reality. But still, it became real at that moment and that allowed me to open- up better." (IntNP02 44, user)
9	Emphasizing the Clients' Own Words and Stories, Not Symptoms	"I feel more accepted here in the state that I feel right now, and then I'm not so busy with a lot of my energy pretending or hiding something, but then I can use that energy to direct it at the real difficulties." (IntN18 88, user)
10	Conversation Amongst Professionals (Reflections) in the Treatment Meetings	"Well, this exchange between the people who came was something special. So easy to talk about it again, to talk about it, which I sometimes felt a bit forced. Somehow because it was part of their concept. And yet I also benefited from it [laughs], I just found it a bit weird in parts." (IntN1 80, user)
11	Being Transparent	"I also thought it was very good that it was so transparent about what is going on with the duty of confidentiality and also the inspection of documents if I want to. This gave me a lot of trust and a professionalism." (IntN1 138, user)
12	Tolerating Uncertainty	"It's a tightrope walk, but here it was accepted, and I wasn't forced to lie and present myself as more stable than I was. Which, for example, I would have had to do with several therapists to be allowed to be in therapy. Because at the end of the initial consultation, they will ask you the question: 'Can I rely on them not to do anything to themselves until our next appointment?' And if I do not want to be taken away and if I want to have this therapy place, then I have to lie. And that's extremely hurtful and frustrating and really does not help you seek help. This did not happen here." (IntN18 52, user)

context and what organizational quality the association offers for the intended practice.

4.1 Cognitive dissonance as a driver for restructuring care

Discussing thesis 1, the established procedures within the conventional psychosocial or psychiatric treatment system led to cognitive dissonance (Festinger, 2020; Weinmann, 2019) among some users, committed practitioners, or laypeople, thereby laying the grounds for the alternative care practices of the Leipzig association. This concept by Festinger (1957) describes a state in which a person simultaneously holds contradictory thoughts, beliefs, or attitudes, which can lead to discomfort and often to a change of his/her attitudes or behaviors. In the context of OD, cognitive dissonance can occur when the conventional, often medicalized approach collides with wishes for alternative approaches (von Peter et al., 2022a; Skourteli et al., 2023). More closely in relation to the project in Leipzig, this dissonance served as the central link to join the network of individuals that are engaged within the context of and around this association. Closely linked to feelings of dissonance may be so-called "moral distress," arising when professionals experience situations in which they cannot act according to their moral or ethical stances due to institutional constraints or other external factors (Kada and Lesnik, 2019; Jansen et al., 2020, 2022). In this context, our analysis seems to reveal that practicing OD may contribute to reducing this form of distress, potentially taking off some of the emotional labor related to it.

From both phenomena, thus, criticism of the prevailing paradigm of psychiatric care may arise, arguing for instance against its

biomedical reductionism, and pathing, as in our project, the way for alternative forms of care that are based on more holistic approaches considering social, cultural, and psychological factors more strongly. Both the feelings of dissonance and moral distress can motivate and concretely shape alternative care practices. The project in Leipzig is not alone in this context. Other highly valuable support initiatives in Germany, in this case a user-controlled one, also emerged from strong criticism (Russo and von Peter, 2022), as well as various historical developments of support organizations in the 1970s/80s (e.g., https://www.pinel.de/, Kempker and Lehmann, 1993), pointing at the value of critical reception and attempts to overcome the discourses and practices of conventional care structures.

Against this background, at least three main approaches of dealing with the experienced shortcomings of the conventional care system can be distinguished: (1) individuals keep on suffering from the system, (2) they try to escape this distress by changing it, or (3) by focusing on efforts to develop alternatives. The latter approach has also been chosen in Leipzig, the distress and dissonance being the significant origin for the foundation of the association and the various forms of sustained engagement. This foundation marked the turn away from the conventional system of various members of the Leipzig "psychiatry-affected/critical scene," consisting of both laypersons and dedicated professionals, embarking on a search for an alternative support culture. During this process, encounters were made with the OD approach, which seemed to offer pragmatic responses to some of this criticism. From the beginning on, a more fundamental change in the overall care system was hoped to emerge from the impetus of the rather niche existence of the association. Thus, the actors in Leipzig were not content with simply withdrawing from the system but always aimed for changes in the direction of a more comprehensive paradigm shift in the psychiatric and psychosocial care systems and related sciences (Kuhn, 1962, 2023).

On this narrow ridge, the described community in Leipzig balances with a current tendency towards increasingly anchoring itself and taking-over more responsibility within the context of the municipal psychiatric care system. Despite this trend, debates about the possibility [or theoretical impossibility (Eichinger, 2009)] to evade the criticized systems continues. Thus, criticism and resistance are dialectically interwoven with the local practices in Leipzig, productively shaping both the organizational form and the support that happens within. Related are ongoing debates on the question, by which means activist or reformist goals can or should be achieved. Concrete steps towards obtaining more secure financial resources are constantly being reflected upon also in relation to their consequences on the support currently offered and democratically voted on. In more fundamental terms, resistant groups and movements are faced with a dilemma: on the one hand, they must fear compromising their own principles and values in moving towards and with the system, while on the other hand, existential needs threaten to disappear into insignificance as an already marginal group (Burstow, 2021). Criticism and resistance must confront these ambivalences; there is no real way out.

4.2 The "Community of Practice" in Leipzig as favorable implementation condition for OD

To substantiate thesis 2, the concept of "Community of Practice" (CoP) served as a sensitizing concept (Lave and Wenger, 1996; Wenger-Trayner and Wenger-Trayner, 2025), defining a group of people that share a common concern or passion and gradually learn how to improve this practice together. In the context of the Leipzig association, the community supporting this practice includes not only members of the association and individuals in regular employment but also freelancers, volunteers, and service users, along with their networks and friends. This composition also recalls the older concept of a "therapeutic community" (Putman, 2022a,b), describing communitarian alliances between professional staff and services users with blurred boundaries that also emerge from shared activities and responsibilities.

Further, the notion of a therapeutic community has been further elaborated by Haigh and Pearce (2017), emphasizing core principles such as democracy, permissiveness, and communal responsibility—values that are also highly evident in the Leipzig initiative. Integrating these frameworks reveals how the Leipzig association fosters a participatory environment that encourages mutual learning and supports recovery through blurred professional-user boundaries, Further the network structure of the Leipzig community aligns with systemic thinking of the OD approach: thus, networking as one of the central principles of OD and both an organizational form and the central feature of the practices or crisis support in Leipzig intertwine in favorable ways, reinforcing each other. Thus, OD as an instrument of community building on a personal level is combined with a bottom-up-structure following grassroots democracy on the organizational level, both converging into an integrated model that focus on and aims at responding to societal concerns (Schmidt, 2017). As an alternative context of support, it holds the potential to forge connections into diverse societal spheres, possibly contributing to overall democratic developments in the larger society. In summary, the emphasis on participation, empowerment, and the activation of social networks in Leipzig has the potential to stimulate a larger cultural shift also beyond the field of psychosocial care (von Peter et al., 2022a).

Both the crises support in Leipzig and its organization involving extensive reflections and metacommunication on the jointly experienced and shaped processes, the technique of the reflecting team is central, and in Leipzig, various supervision formats are given more space compared to other health care contexts. During these formats, the participants learn from each other and support each other to integrate what they have learned back into practice—a process that can also have transformative effects on the related networks (Akinsooto et al., 2020; Tsimane and Downing, 2020). This exchange and feedback loops in all directions keeps the work in the association open to new influences and prevents the practiced OD from becoming monological or too dogmatic. The necessary listening and reaching out of the actors in the networks are fundamental features of such a learning organization (Zinner, 2014) and, further, are important for the transformation of societies and the other organizational systems developing within them.

Thus, Leipzig's OD practices demonstrate potential for broader societal impact, aligning with Gregory's (1982) theories of gift versus commodity exchange and social capital development. The initiative's focus on trust-building and democratic participation exemplifies how grassroots mental health innovations can contribute to a cultural shift prioritizing collaboration and mutual empowerment over transactional relationships. This aligns with international trends emphasizing the role of social networks in promoting community well-being (Florence et al., 2020).

In this context, youth and little experience as a consistent personal characteristic of the active players in Leipzig are also striking. Youth like this makes the team more open and flexible to the path into the unknown. Further, employees are not yet socialized in conventional professional roles but are freer to look for their own professional identity. The development of the association so far has given them the space to structure their activities according to the needs of the concept and the people involved. At the same time, the process of implementing the new individuals interested to join the team requires the agile structures to succeed, a process that is hardly manageable within traditional structures, mainly basing the work on conventional competencies or working methods without too much freedom to build-out another style of support (Weber, 2014). Further, the association's emphasis on younger professionals reflects the OD principle of "unlearning" entrenched roles and adopting a "not-knowing" stance, as described by Wilfred Bion (Simpson and French, 2001; Goddemeier, 2023). These characteristics enhance adaptability and creativity, allowing for experimental practices in a low-hierarchy setting. The youthful openness of the team facilitates the development of new professional identities unburdened by traditional psychiatric paradigms, fostering a culture of innovation and responsiveness to community needs.

Thus, the association in Leipzig can be seen as a stimulating example of a learning organization by relying only on a few structurally designed hierarchies, which benefits these learning processes. Fundamental to these processes are also the more permeable boundaries between the organization and its environment comparing them to more conventional organizational context of mental health care: both only initial steps of participation and more permanent forms of engagement are possible in Leipzig, sometimes even without a contract or without fulfilling the usual formal qualifications—a network structure that seem to function even without formalized commitments (Klärner et al., 2020). Instead, an open space has been constituted where a culture of welcome is lived, allowing people low-threshold access and exit (Carrel, 2013). Such a culture naturally raises many questions that require ongoing discussions in everyday life, also in Leipzig: How must such a space be constituted or maintained? How open must/ should it be, and who decides on its structure? In answering these questions, the participation of various people and networks external to the association in Leipzig seems to play a role too. In addition to the joint crisis support, there are a few spaces to exchange on these questions, marking smooth transitions between the status of a person that is being supported to one that may contribute to co-designing the structures of support, enabling joint creativity during this process.

In relation to these organizational peculiarities, the uniqueness of the association can be stated in two ways: firstly, in relation to the implementation of OD in Germany and internationally, and secondly, compared to other providers in the Leipzig service region.

4.3 OD Leipzig as a potential implementation model

The background for the third thesis is the observation that the association in Leipzig, with its very specific history and current configuration, offers a good opportunity for implementing OD in Germany. The above-reported results demonstrate that crisis support according to the principles of OD largely succeeds in Leipzig. In the results section, this fidelity was reconstructed based on the statements of users (see Table 4) that highlight the commitment to the OD key elements (Olson et al., 2014) from their perspective. Accordingly, the project offers sufficient scope on both an organizational and therapeutic level, which, compared to the OD implementations in other health care contexts in Germany, can be described as unique (Heumann et al., 2023). To illustrate this into more detail, the usual implementation problems of OD both nationally and internationally are discussed subsequently, followed by a more general elaboration on the contextual requirements for the optimal implementation of the OD approach.

As described elsewhere (Heumann et al., 2023), the implementation of OD in Germany faces various challenges at systemic, organizational, and individual levels: systemically, the fragmented healthcare system poses problems in clarifying responsibilities and necessary cooperation across sector boundaries. Further, the systemic work within networks is currently not financially rewarded. The same, usual services are oriented towards the achievement of goals and solutions as quickly as possible, with less possibilities for ongoing and potentially long-lasting network processes as practiced in the OD approach. On the organizational level, the implementation of OD often is hindered by traditional working approaches and staff turnover. It is difficult to embed the concept within an organization without obtaining sufficient support from the management level. Individually, a frequent lack of a suitable mindset among employees is described to adopt this new way of working, which at times may entail radical changes on the level of the organizational culture. In addition, the redistribution of responsibility and thus power in the therapeutic process often encounter resistance, which can lead to fatigue.

Similar problems are described internationally. Skourteli et al. (2023) summarizes findings from Scandinavia and beyond in her report before discussing challenges of OD implementation in a day clinic setting in Greece: even in Scandinavia, interprofessional cooperation is described to not always succeed, the separation by expert roles and hierarchical structures leading to uncertainties. Further, it is described how fundamental organizational change, related to the implementation of OD, provokes resistance at all levels. Outside Scandinavia, the dominant biomedical model is seen as inhibiting. From an economic perspective, the costs of training and complex accounting modalities are significant obstacles to such an implementation (Florence et al., 2020). Translating the OD approaches to local contexts and cultures, further, poses various challenges.

A central contribution of this study is the examination of Leipzig's bottom-up OD implementation compared to top-down strategies in other contexts, such as the UK, Italy, or South Korea. Grassroots adoption in Leipzig emerged organically from the collective experiences of professionals and service users disenchanted with conventional psychiatric care. In contrast, top-down implementations often encounter challenges such as hierarchical resistance and rigid organizational structures (Skourteli et al., 2023). While top-down strategies may benefit from systematic resource allocation and training, grassroots initiatives, like Leipzig's, capitalize on flexibility, democratic participation, and community-driven innovation. This distinction underscores the potential for hybrid models that combine grassroots dynamism with institutional support, fostering sustainable OD practices globally.

Given the current state of the mental health care system in Germany (and elsewhere?), it remains to be asked, how a change towards the direction outlined above can be fostered. For this purpose, actors within and outside the system are needed that are willing to engage disproportionately, in the sense of "engaged practitioners" (Waddoups, 2022; Bell et al., 2010), contributing to change at various levels of an organization or the wider system. In addition, theoretical contributions from research and sciences are also needed, influencing and facilitating practical developments and transformation. Methodologically, participatory and ethnographic approaches as well as action research and discourse analyses, combined with a high level of engagement ("engaged science"), appear promising for this purpose: (https://www.engagingscience.eu/en/, Keller and Limaye, 2020).

What can be learnt from our study: to implement the OD approach, organizations need flat hierarchies, transparency in their processes, and a clear orientation towards participation and collaboration. There is a need for opening the institution and for creating conditions that facilitate transformative learning. Such flattening or dissolution of existing hierarchical structures in psychiatric care institutions seems like an overwhelming task, given the current state of usual health care institutions, but this is necessary to create space for processes described above. The ideal case of a grassroots democratic structure, such as in Leipzig, despite its mainly financial shortcomings, seems to be feasible but may currently only be outside of the organizational frame of the usual care systems. Given wider developments in society (such as the dismantling of democracy, the rise of authoritarian political positions, the economization of healthcare, as well as the psychiatrization of society), always shaping the context of psychosocial work too, thus, a full implementation of OD according to all its principles, at least in Germany seems distant outside of subcultural niches (Asseburg and Goren, 2022; Zick et al., 2023; Köchert, 2015; Vaudt, 2022; von Peter et al., 2021).

On a personal level, a specific mindset seems necessary to work in line with the OD approach. Traditional expert roles must be abandoned in favor of acknowledging diverse expertise that not only draws on academic and professional sources. Working in multiprofessional teams including peer workers, and across sector boundaries should be the norm, and participants should be trained for this purpose (Hendy et al., 2023). Theoretically grounded in our data, the above-mentioned concept of a Community of Practice can be useful in this context to form a shared interest in shaping and developing support practices together. Such communities, besides their more direct engagement in OD practices, could be more involved in processes of its implementation, also to work on appropriate financing conditions on an economic level. In the association in Leipzig, for instance, individuals or groups can be found who are dedicated to political and lobbying work to drive systemic changes. A community of practice, further, could integrate research, thereby linking to staff or resources at universities, research institutes, or science shops (Benz et al., 2022).

Last, finding suitable options to account for work according to the OD principles within the healthcare system would be a recommended task for a group of "engaged economists" including health policymakers. A sustainable funding model would be a milestone towards establishing this approach in Germany. It would financially secure professional practice and allow therapists to dedicate themselves fully to this work without existential worries or without having to find ingenious structural solutions. It would be easier for management in clinical departments and other health care institutions to support OD practices and their development, providing for convincing arguments also from an economic perspective. Global treatment budgets are a new financing option for flexible and cross-setting work practices, which have already been tested for psychiatric pilot projects according to §64b SGB V (Schwarz et al., 2022). They could also promote the implementation of OD in Germany if rolled-out to a larger scale.

5 Conclusion

In a time when the healthcare system is increasingly being critically scrutinized, the establishment and development of a grassroot association for crisis support underscores the necessity of alternative care models. Shaped by personal experiences with the existing psychiatric system, moral distress, and cognitive dissonance, a group of individuals who had either experienced crises themselves or professionally supported others through them, leading to the aspiration to create a space for change. As described above, this manuscript is to be seen as an intermediate product on the way to a more fully developed theory. Such a development of a consistent theory in accordance with the logic of the GTM theory formation was not possible within the framework of the underlying research. Nevertheless, two theoretical derivations will be presented here in a condensed form: first. The process of dissonance reduction and second, the redistribution of power and responsibility in the mental health care system.

Concerning the process of dissonance reduction, a diagram in Supplementary Figure S4 (Supplementary Figure S4 summarizes the course of the development process of the Leipzig association. as it emerged from our research data. The straightforwardness of the diagram is a simplification of the complex processes described and for the sake of a clear visualization. Here is a summarised description of the diagram in Supplementary Figure S4): The experiences with the conventional system bring about dissonance and the search for alternatives. The common interest brings people/peers together and they look for suitable concepts. The action begins with concrete plans for implementation. The participants develop into new roles and build a learning organisation. The first results become visible: new professional identities emerge during the work experience in a new type of organisation. An innovative practice is designed, and new things are created using swarm intelligence. For the players involved, this can mean a reduction in the dissonance that triggered this process.

The fact that regression can occur again over the course of time is shown below in the topic of power and responsibility. In relation to the second conclusion, the institutions of conventional psychiatric care are powerful in multiple respects: (1) they usually operate via hierarchical structures; (2) diagnoses are used that can lead to the stigmatization of those affected; (3) coercive measures against patients can be seen as an extreme form of exercising power; and (4) the way in which funding and resources are allocated determines which treatment approaches are pursued and paid for, while others are marginalized. The path taken by the association in Leipzig shows several attempts to redistribute these forms of power. The underlying democratic impulse redistributes power to people in psycho-social emergencies, their networks and professionals that strive for support alternatives. To this end, committed practitioners are giving up positions that the traditional system holds for them in favor of working in a grassroots democratic organization that can only exist in a social niche for the time being. Economic success has yet to

materialize and sustainable implementation of this support alternative is an enduring challenge.

At the same time, the results of our research suggest that this association in Leipzig, with its specific history and current structure, presents a suitable opportunity for the implementation of OD in Germany and in the local context of Leipzig. This conclusion is supported by identified organizational conditions and competencies of the involved individuals that facilitate the implementation of OD. We observe an exceptional and necessary freedom at the organizational and individual level, namely, from long-established and entrenched structures, which, compared to other implementations of the concept in Germany, can likely be described as unique.

5.1 Strengths, limitations, and outlook

This study demonstrates several *strengths*: the participatory approach was pursued sustainably from the outset and maintained over an extended period, fostering a thorough and inclusive process. Despite limited financial support, the research team sustained a long and continuous investigative process, marked by openness to reflection and methodological creativity. The diversity and interdisciplinarity of the research team contributed to methodological and theoretical innovations that enriched the study.

However, the study has its *limitations*: The analysis primarily relies on a retrospective view of the research object (the people interviewed had already completed their crisis support, and some staff members had not been involved in this support for some time when the interviews took part), with limited opportunities for field research in more depth. Furthermore, while dissonance and its resolution emerged as important themes, these processes could not be explored in depth at an individual level. Additionally, aspects related to the effectiveness of Open Dialogue (OD) were beyond the scope of this manuscript. In the area of theory development, further empirical steps on the path to a complete theory could not be taken. The people involved in the project were too engaged in other tasks.

Several *open questions* remain *for future research*: Can the theoretical derivations from the project be developed into a consistent middle-range theory? What steps would be necessary to follow the logic of theory formation? If the outcome of this process is promising the next step were testing the middle range implementation theory across various implementation contexts and conducting in-depth comparisons of specific historical implementation processes of OD. Further exploration of the dissonance concept and its relation to similar theories like 'resistance', 'reluctance' or 'ambivalence', especially within the context of professional socialization across different healthcare systems is warranted. Moreover, defining meaningful, network-related outcomes to evaluate OD effectiveness is a critical step forward, with potential comparisons to psychotherapy research focusing on systemic approaches.

Data availability statement

The datasets presented in this article are not readily available because access should be discussed in the group of participants. Requests to access the datasets should be directed to Thomas.Klatt@mhb-fontane.de.

Ethics statement

The studies involving humans were approved by Ethikkommission der Medizinischen Hochschule Brandenburg. The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation was provided by the participants.

Author contributions

TKl: Conceptualization, Investigation, Methodology, Resources, Writing – original draft, Writing – review & editing. LC: Formal analysis, Investigation, Methodology, Validation, Writing – review & editing. TKr: Data curation, Investigation, Resources, Validation, Writing – review & editing. IN-H: Data curation, Investigation, Resources, Validation, Writing – review & editing. SS: Data curation, Investigation, Resources, Validation, Writing – review & editing. SP: Conceptualization, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2025.1426116/full#supplementary-material

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Peer support and shared decision making in Open Dialogue: Opportunities and recommendations

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Open dialogue (OD) is a person-centred social network model of crisis and continuing mental healthcare, which promotes agency and long-term recovery in mental illness. Peer support workers who have lived experience of mental illness play a key role in OD in the UK, as they enhance shared understanding of mental health crisis as part of the OD model and provide a sense of belonging and social inclusion. These elements are in alignment with the shared decision making (SDM) approach in mental health, which focuses on person-centred communication in treatment decision-making. The previously documented benefits of peer-led SDM include increased engagement with services, symptom reduction, increased employment opportunities, and reduced utilization of mental and general health services. While the contribution of peer support and SDM principles to OD has been acknowledged, there is only a small body of literature surrounding this development, and little guidance on how peer support can enhance treatment decision-making and other aspects of OD. This viewpoint, which was co-authored by people with lived experience of mental illness, clinicians, and researchers, discusses practical implications and recommendations for research and training for the provision of a co-produced OD model grounded in peer support and SDM.

KEYWORDS

peer support, shared decision making, Open Dialogue, mental health, mental illness, peer support workers, lived experience

Introduction

Open dialogue (OD) is a person-centred model of mental health care that is based on collaboration between a clinician, a person experiencing a mental health crisis and their social network (SN; e.g., family members, friends, and carers) (Seikkula et al., 2001; Seikkula and Olson, 2003; Olson et al., 2014; Pilling et al., 2022). OD is both a therapeutic practice and a way of organizing services (Seikkula et al., 2003). The central means of intervention delivery are through network meetings: reflective conversations between people who access mental health services and their social or professional environments to enable a mutual and deeper understanding of the current crisis, as well as to draw on the resources of the network and facilitate inherently democratic and transparent decision-making (Aaltonen et al., 2011; von Peter et al., 2021). OD aims to protect and promote the autonomy of people who access mental health services: respect their choices, priorities, and values (World Health Organization, 2021).

Peer support is increasingly recognized as an important and transformative element of mental health care (Maruthappu et al., 2014) provided by people with lived experience of mental illness, which involves giving and receiving help based on self-determination, respect and social inclusion, shared responsibility and mutual agreement on what could be helpful (Mead et al., 2001; Dennis, 2003). Peer support exists along a continuum, from informal, mutual relationships of connection and support at one end to more formal relationships in which people with lived experience of mental illness are employed to help at the other (Bradstreet, 2006; Davidson et al., 2006). The lived experience of peer support workers (PSWs) can improve decision-making by mirroring people who access mental health services to voice their concerns and priorities, values and preferences (Cleary et al., 2018).

In the UK, peer support makes a unique contribution to OD as PSWs are trained to take on dual roles of experts by experience and as community navigators within their clinical teams (Razzaque and Stockmann, 2016; Bellingham et al., 2018). As experts by experience, PSWs have a psychotherapeutic role alongside clinicians in network meetings where they engage in self-reflections to help people who access mental health services and their SNs feel heard, respected and validated. PSWs can therefore facilitate transparent decision-making about treatment and recovery through open dialogue and collaboration between all members of a SN meeting. Secondly, as community navigators, they have a more professional role, in which their expertise is used to help individuals with a limited SN link up with people who currently receive (or have received) support from local mental health services. It will be a self-help community that the PSWs facilitate and bring forward as a resource for those who can benefit from it.

The dual role of PSWs in OD is in alignment with the shared decision making (SDM) approach in mental health, which focuses on person-centred communication in treatment decision-making, with the goal of improving experience of care as well as clinical and functional outcomes (Zisman-Ilani et al., 2021c; Zisman-Ilani and Byrne, 2022). Indeed, the key principles of SDM in OD include (1) the reduction of power asymmetries between a clinician and a person accessing mental health services; (2) the recognition that there are at least two expert participants: a person with lived experience, a clinician with professional expertise and a SN member; (3) the expression of preferences of the person accessing mental health services for involvement in decision-making and the expression of their specific values that could guide the decision; (4) the discussion of at least two treatment options; (5) making or postponing a decision that is consistent with the patient's goals, preferences and values; and (6) accepting that the patient's choice of treatment plan may differ from the clinician's recommendation (Zisman-Ilani et al., 2021c).

However, bringing together peer support and OD may not necessarily be straightforward in practice. Barriers to the successful implementation of peer support in OD may include lack of role clarity (Crane et al., 2016), prioritization of clinical decision-making (including prescribing decisions), (Zisman-Ilani et al., 2017) stigma and negative attitudes of clinicians, (Wheeler et al., 2020) lack of clear boundaries between PSWs and people who access mental health services, (Miyamoto and Sono, 2012) poor team functioning, limited career opportunities, and inadequate training, supervision, and logistical support for PSWs (Vandewalle et al., 2016). Therefore, the development of a co-produced OD model grounded in peer support and SDM can help overcome these barriers and embed a culture-change in mental health services.

We, the authors of this viewpoint, have an interest and experience in receiving and delivering OD treatment. We believe that potential contributions of peer support and SDM to OD include the development of meaningful relationships that empower people who access mental health services and their SN to manage their own care and treatment (Bellingham et al., 2018); the promotion of democratic partnerships between clinicians and people who access mental health services, and the reduction of clinical hierarchies in mental health services (Razzaque and Stockmann, 2016); the humanization of mental health services where delivering person-centred care is a top priority, (Youngson and Blennerhassett, 2016) the promotion of greater understanding of peer support perspectives, (Stockmann et al., 2019) and the promotion of recovery-oriented care (Razzaque and Stockmann, 2016; Bellingham et al., 2018). Therefore, the pairing of the two approaches and their implementation and adoption in the UK mental health services

has a revolutionary potential to change the way we respond to human distress.

Peer support and shared decision making build meaningful and empowering relationships in mental health services

The development of meaningful relationships is central to peer support in OD so that people who access mental health services can feel supported to reflect and express their preferences and views during the decision-making process (Adame and Leitner, 2008). PSWs bring together both social and professional networks by establishing connections between clinicians, people who access mental health services and their family. The role of a clinician focuses more on maintaining established relationships with members of the SN (Razzaque and Stockmann, 2016) than on rushing to agree or provide expert advice. There is also a strong emphasis on the mobilization of resources within people who access mental health services and their SN to increase feelings of agency and the ability to develop and maintain mutually supportive relationships in the longer term (Pilling et al., 2022). Consequently, people who access mental health services and their SN are encouraged to make their own decisions about their health and treatment, demonstrating the emancipatory and empowering potential of peer support in OD.

Peer support and shared decision making promote democratic partnerships in mental health services

Peer support in OD engages in dialogue from different perspectives and tries to privilege all voices, which would necessarily include the voices of clinicians, people who access mental health services, members of their SN and PSWs (Bellingham et al., 2018). Peer support in OD also asks clinicians to abandon the position of expert-by-knowledge and practice from a place of "not knowing" (Anderson, 1990). By not having prior medical education and training and yet finding the courage to speak out and share their views and experiences of mental illness, PSWs can help clinicians give up the authoritarian role, lean into uncertainty, tolerate risks, (Scott, 2011) and facilitate spaces to discuss treatment openly and democratically. PSWs can promote democratic partnerships, especially in more complex decision-making situations, such as psychiatric medication management, as SDM is often perceived as a risk to clinicians due to liability and clinical errors (Zisman-Ilani et al., 2021b). Indeed, research into how SDM occurs at psychiatric medication management meetings has shown that clinicians often use persuasion in encounters with people who access mental health services, and concerns about adverse effects are often ignored (Quirk et al., 2012; Kaminskiy and Finlay, 2019). Peer-led SDM in OD can therefore place a greater emphasis on personal meanings and a broader psychological and social understanding of medication, strengthening the ideal of a meeting of different experts (i.e., experts-by-experience versus experts-by-knowledge) and the value of experiential knowledge encounters (Ramon et al., 2017; Leendertse et al., 2021).

Peer support and shared decision making humanize mental health services

Peer support in OD embodies the key principles of person-centred care, such as dignity, compassion, respect, choice, and empowerment. Peer support in OD emphasizes co-production and active citizenship in recovery (Ramon, 2018) to promote a better understanding of the perspectives of lived experience of mental illness (Stockmann et al., 2019). PSWs offer people who access mental health services the opportunity to share common experiences of stigma and discrimination, to help them develop new insights into their own mental health and protect them from feelings of shame, social alienation and isolation (Bellingham et al., 2018). PSWs ask clinicians to reflect on their own lived experience of mental illness whenever possible and bring more of themselves into network meetings (Olson et al., 2014; Stockmann et al., 2019). PSWs do not share the systemic culturalization of clinicians and have a more nuanced understanding of mental illness that can inform care practices. PSWs view crisis as temporal and episodic, and recovery as a deeply social, unique, and shared process (Baumgardt and Weinmann, 2022). PSWs can therefore restore human values by focusing on listening and responding to the whole person in a context rather than primarily focusing on their symptoms.

Peer support and shared decision making are the key components of recovery-oriented care

Peer support in OD shares common values of the recovery model of mental illness such as hope, self-determination, empowerment, community integration and advocacy (Onken et al., 2002). These values challenge personal narratives of distress by exposing the need for recovery from iatrogenic harm and restrictive treatments (Bellingham et al., 2018). By sharing

their experiential knowledge, PSWs support people who access mental health services in initiating and maintaining recovery and improving the quality of their personal, family and social lives (White, 2009). Since OD is intended to reflect the core interests of people who access mental health services, questions arise about how the outcomes used to evaluate peer support and SDM in OD align with the outcomes they value. The lack of a clear definition of peer support and SDM in OD, (Shalaby and Agyapong, 2020; Zisman-Ilani and Byrne, 2022) the holistic nature of recovery outcomes, and the fact that mental illness affects almost all aspects of life (e.g., housing, SNs, employment, education, mental health, and health care treatment) have led to different conclusions on which areas should receive the most attention and why (Whitley and Drake, 2010).

Discussion

Peer support and SDM are increasingly recognized as the central pillars of recovery from mental illness. This is based on the important premise that the meaning of recovery can be different for everyone, and that people can benefit from sharing experiences, being listened to and respected, being supported to find meaning in their experiences and a path to recovery that works for them, ultimately enabling them to lead a fulfilling and satisfying life (World Health Organization, 2021). Therefore, recent efforts to include peer support and SDM in OD hold promise and highlight different points of convergence between them. Both OD and peer support practices are concerned with different meanings of distress, emphasize collaboration and democracy, and SDM in care and treatment for mental illness. Furthermore, the OD principle of "tolerating uncertainty" is not entirely different from the principles of peer support of "not knowing" and "dignity of risk," which support self-determination and seek to avoid risk-averse practices (Mead and Hilton, 2003; Repper and Carter, 2011; Scott et al., 2011). Nevertheless, research attempts to determine how peer support can enhance SDM and other aspects of OD highlight important challenges and opportunities that researchers and health care providers are encouraged to consider.

The core principles of peer support and shared decision making in Open Dialogue

Peer support workers are employed members of the clinical team who make a unique contribution to network meetings by using their lived experience to engage people who access mental health services in their treatment. Nevertheless, the current descriptions of PSW roles are too general, and there is little rationale for positioning peer support in the OD approach broadly and in network meetings, more specifically. The study of the impact of peer support on mental health using statistical approaches is therefore limited, and does not fully take into account people and their unique characteristics, as it mainly emphasizes the importance of qualitative research in this field (Bellingham et al., 2018). Clarifying the core values and principles of the PSW role in OD will ensure that, as peer support grows, it grows with integrity to its founding values and remains distinct from other mental health interventions that are not based primarily on the person's own life experiences.

The core outcome set for Open Dialogue research and clinical practice

Clinical outcomes such as psychiatric hospitalizations or psychiatric symptoms remain a focus of peer support and SDM in mental health research, and contribute to a mixed evidence base for the effectiveness of OD interventions for the treatment of mental illness, with recovery-oriented outcomes such as empowerment, self-efficacy, and hopefulness being the main outcomes (Salyers and Zisman-Ilani, 2020; Zisman-Ilani et al., 2021a). The lack of validated outcome measures uniquely developed to assess peer support and SDM in mental health is a critical factor that contributes to the limited use of recovery-oriented peer support and SDM outcomes. A useful strategy is to consider which outcomes are valued by the people who use services, and to develop an evaluation approach based on these objectives. Person-driven measurement approaches and more participatory research methods can improve both the quality and impact of health and mental health services. Therefore, an agreement must be reached on a core outcome set for measuring peer support and SDM as part of recovery-oriented care in OD (Wheeler et al., 2020).

Conclusion

This viewpoint emphasizes the potential contributions of peer support and SDM to the provision of a co-produced OD model. Peer support and SDM are at the heart of person-centred care and personal recovery. An updated OD model grounded in peer support and SDM sets a new direction for OD research, with the emphasis on developing and validating peer support and SDM measures with and for people who access mental health services. Such a model goes beyond simply pairing the two approaches and deliberately requires the inclusion of a competence framework that considers the strengths of peer support and OD. This new framework can provide a better understanding of how PSWs add value to the competences of OD teams and services. It can also protect people working in PSW roles from being asked to work in inappropriate ways,

either beyond their competence or in a way that does not make the best use of their skills.

Data availability statement

The original contributions presented in this study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Author contributions

MC wrote the first draft of the manuscript. YZ-I read and revised the draft further. NM and AT served as a driving force behind the concept and provided guidance on how to structure the manuscript. All authors contributed to the article and approved the submitted version.

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Conflict of interest

YZ-I is a member of the Patient-Centered Outcomes Research Institute's Advisory Panel on Clinical Effectiveness and Decision Science.

The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Conceptualizing the peer contribution in Open Dialogue practice

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In English mental health services, people with their own experience of mental distress have trained as Open Dialogue practitioners and have been employed as peer practitioners, co-working as equals alongside workers with professional backgrounds in Network Meetings. The conceptual underpinnings of the peer practitioner role have been drawn from the principles and relational approach of Intentional Peer Support. These have significant similarities with Open Dialogue, in terms of philosophical and theoretical orientations, with a particular focus on what happens in the "between" of a relational encounter. However, there are also significant differences in how practice principles are conceptualized, particularly around areas such as mutuality and self-disclosure. This article offers an analysis of this conceptual territory drawing on the relevant literature. This is then taken forward with the teasing out of specific practice principles that capture the unique contribution that peer practitioners can bring to Open Dialogue practice. These are derived through discussions that took place in an Action Learning Set for peer practitioners who have been involved in delivering Open Dialogue services in mainstream mental health service settings. This was part of a wider research study entitled *Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESSI).* The principles address how peer practitioners may be particularly well-placed to offer attunement, validation, connection and mutuality, and self-disclosure – and hence how they may be able to contribute an additional dimension to dialogical practice.

KEYWORDS

Open Dialogue, peer support, practice principles, attunement, validation, connection and mutuality, self-disclosure

Introduction

In England, the development of Open Dialogue has received strong support from many who have used, or are using, mental health services, as well as from family, friends and practitioners. It is seen as offering a more open and inclusive way of working with mental distress. In many instances, Open Dialogue is being introduced into services where the role of peer workers is also being developed – opening up new opportunities, but also raising certain challenges in terms of how the two approaches might best be integrated. In the United States, peer workers were integral team members in the roll-out of the Open Dialogue inspired Parachute NYC in New York. Despite some challenges with structural constraints around the introduction of peer specialists, this project established the principle that they should be considered as equal practitioners, rather than as support workers assigned to practical tasks outside of Network Meetings (Hopper et al., 2020; Wusinich et al., 2020). Internationally, we have seen other

developments of Peer supported Open Dialogue practice (see for example, Lorenz-Artz et al., 2023).

Within the United Kingdom, the Peer Practitioner role has been a key component within some Open Dialogue teams since 2014, and peers have trained and become accredited Open Dialogue practitioners or therapists, with the potential to effect positive clinical outcomes and experiences (Razzaque and Stockmann, 2016; Kinane et al., 2022). The first national multi-site trial evaluating Open Dialogue in English NHS mental health services – Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESSI) – has included an explicit commitment to peer practitioner involvement in multidisciplinary teams (Pilling et al., 2022). Peer supported Open Dialogue (POD) may be seen as a variation of the Open Dialogue approach as originally developed in Western Lapland and guided by the same principles, with the added contribution of peer practitioners who have their own experiences of crisis, mental distress and personal recovery, and (in many instances) of using mental health services.

The development of peer worker roles in mental health services has often been somewhat *ad hoc*, with insufficient thinking about the nature of the role and how this should be supported. In particular, there can be some confusion and inconsistency between peer support and peer practitioner roles in services and teams (Grey, 2019). This has resulted in experiences and outcomes – both for service users and for the workers themselves – which have not always been entirely positive (Gillard and Holley, 2014; Vandewalle et al., 2016). Both internationally and in the United Kingdom, the more focused peer practitioner roles have often been inspired by the Intentional Peer Support (IPS) model (Mead and MacNeil, 2006; Grey, 2019). IPS offers a way of building purposeful relationships between people who have direct experience of mental distress. It is a process where both parties use the relationship to look at the meaning of their experiences from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other. It is a practice that is fundamentally dialogical – and hence has the potential to provide a good "fit" with the principles of Open Dialogue. For example, as Kemp et al. (2020) observe, "the OD principle of 'tolerating uncertainty' is not entirely different to peer support principles of 'not knowing' and 'dignity of risk', which support self-determination and seek to avoid risk-averse practice" (p. 58).

While the Treatment Principles that define Open Dialogue practice are well established (Seikkula et al., 2003), there is now an opportunity to revisit these, in conjunction with those of IPS, in order to clarify the conceptual underpinnings of the emergent peer practitioner role in Open Dialogue. In this Paper, we start to map out what this might look like, drawing both upon the relevant philosophical and practice related literature, and on discussions that took place in an Action Learning Set for peer practitioners who have been involved in delivering Open Dialogue services linked to the ODDESSI research trial (Pilling et al., 2022). We hope that this can better articulate "a coherent and profound narrative" about POD, and what this may contribute to the development of dialogic practice (Lorenz-Artz et al., 2023).

Conceptual starting points

Alongside Tom Anderson's reflecting teams family therapy approach (Andersen, 1995), Open Dialogue represents a decisive break with earlier systemic practice in which "expert" conversations took place behind a one-way screen in parallel with the therapeutic conversation taking place with (and between) family members (Sidis et al., 2022). The function of these conversations was to generate hypotheses and formulations, using the combined inspirations of a supervisory team to outmaneuver resistances to change within the organization of a family system. Crucial to the break was a shift from a hierarchically organized discourse to a democratic practice of an "open" dialogue in which all conversation takes place in the room and draws upon the language and forms of expression that are being used by the person experiencing mental distress and those who were part of their relational network. As Jakko Seikkula writes,

> "Perhaps as therapists we are so used to thinking so much about being skillful in methods and interventions that it is difficult to see the simplicity. All that is needed is to be present and to guarantee that each voice becomes heard" (2008, p. 489).

This conception of dialogue harks back to the existentialist idea of the authentic "I Thou" encounter as originally described by Buber (2000), with its focus on the potential for something new to emerge in the "between" of an encounter that is more than the individual contributions of those involved, and which has the potential to shift the experience (and understanding) of self *and* other.

There are similar echoes of the "I Thou" encounter in how dialogue is conceptualized in Intentional Peer Support. As Shery Mead writes,

> "In real dialogue, we are able to step back from our truth and be very deeply open to the truth of the other person while also holding onto our own. When this type of dialogue occurs, both of us have the potential to see, hear, and know things in ways that neither of us could have come to alone" (Mead, 2014, p. 8).

She explicitly focuses on the importance, and creativity, of the "between" space:

> "When we pay attention to the relationship … we are paying attention to what is going on between us. In other words, we focus on the "space" between us, what is happening right here, right now that can either move us forward or back…. When I pay attention to what's going on between us, it opens up a line of communication that supports honesty, safety, integrity, and ultimately changes the very direction I had wanted to go without you" (Mead, 2010a, p. 13).

A pre-requisite for dialogue is taking time to establish an authentic personal connection. In IPS, this is described as "the bond that is created when people feel genuinely understood and trusting enough to go deeper" (Mead and Filson, 2017, p. 147). For Open Dialogue, cultivating such a connection with the person is equally crucial. International research on peer supported Open Dialogue shows that many peer practitioners believe the idea of "peer" to be about relationships rather than roles or identities (Grey, 2019). Mary Olson and colleagues argue that there should be no "ready-made solutions" or "pre-planned interventions" in Open Dialogue (Olson et al., 2014, p. 27). This strongly relates to the practice principle of tolerance of uncertainty (Seikkula et al., 2003), and an intention to keep the focus

on "connection – as opposed to direction" (Razzaque and Stockmann, 2016, p. 352).

For Mead, there is a crucial distinction between peer support more generally, which may involve *helping* the other, and Intentional Peer Support which is about a fundamentally mutual process of *learning* with and from each other:

> "Learning implies a curiosity, an inquisitiveness about the other, their way of knowing, their way of making sense of the world, whereas helping often implies that you already have the answers, that you know better, that you can come in and tell someone what to do" (Mead, 2010a, pp. 12–13).

This may not happen immediately, and time may be needed for people to become connected enough to allow the expression of emotionally charged experiences, after which there may be an emergence of a "between" space in which it may be possible to develop "a new 'shared' story" (Mead and Hilton, 2003, p. 89).

Although Open Dialogue and IPS may share some common conceptual roots, there can be some tensions as to how this "in-the-moment" openness translates into therapeutic practice. Is dialogue ultimately more of a one-way process in which the practitioner learns and explores the experiences, meanings and understandings of a person (and those close to them), but remains a bit of a "closed book" with the participants in the room having less opportunity to encounter the personhood of the practitioner? Or is it founded on the mutuality of peer relationships in which participants are continually learning of and from each other, and where both may be moved and changed through their encounter with the other? Although it is acknowledged that it may get "tricky when one person is paid" (Mead, 2014 p. 13), it is nevertheless core to IPS that Peer Practitioners put their whole selves "into the equation" (Mead, 2010a, p. 13) – hence a focus on the importance of relevant and appropriate self-disclosure as a key element of peer practitioners' practice. In turn, this may provide a challenge – and an opportunity – for Open Dialogue practitioners who are not peers to be more open and disclosing of themselves within the therapeutic process.

A second area where there is significant shared ground between Open Dialogue and IPS is a phenomenological concern with meanings and interpretations – how we make sense of our experience and the possibility that there are always new ways of making sense that may emerge through connecting dialogically with others. Seikkula and Olson suggest that psychosis (and potentially other manifestations of mental distress) can involve a "temporary radical and terrifying alienation from shared communication practices: a "no-man's land" where unbearable experience has no words and, thus, the patient has no voice and no genuine agency" (Seikkula and Olson, 2003, p. 409). Dialogue therefore involves reaching out to connect with others' frames of expression and understanding "in order to develop a common verbal language for the experiences that remain embodied within the person's … speech and private inner voices and hallucinatory signs" (Seikkula and Olson, 2003). This hermeneutical quest stands in radical opposition to more traditional mental health practices in which a dominant medical or psychological way of seeing can be imposed on what may seem dissident, anarchic or irrational. In order to safeguard the dialogical "between" space in which new language and understanding can emerge, a core principle of Open Dialogue is the tolerance of uncertainty and a willingness on the part of the practitioner to be comfortable in a place of "not knowing" for as long as it takes for meaning to emerge.

Taking a more explicit social constructionist stance, IPS invites people to "consider the possibility that there are many truths out there" (Mead, 2014, p. 6), inviting them to deconstruct dominant (and perhaps now habitual and internalized) ways of seeing and being. For example, instead of finding "ourselves falling into psychiatric assumptions about ourselves or others" (Mead, 2014), the uncertain and sometimes risky process of dialogue may create a space in which new and alternative meanings emerge, ones which may return to people opportunities for reclaiming voice and agency. Fundamentally, IPS is about conversation. It's about how we … create new "knowing" through dialogue (Mead, n.d.). This co-creation of "new knowing" is given more of a political stance and purpose than in Open Dialogue: it is not just about breaking through the terrifying hermeneutic isolation of mental distress, it is also seen as purposive in bringing about social change – change that is predicated on hearing and learning from the suppressed meanings and experiences of those that may have undergone trauma, abuse and oppression (Mead, 2010b).

In finding ways to conceptualize ideas of plurality and indeterminacy, Open Dialogue draws upon the philosophical work of Mikhail Bakhtin. Bakhtin saw dialogical relations constructing everyday life, where meaning only emerges through dialogue. Identities and performances are always seen to be in flux and inherently unfinalized, continually open to being shaped by new encounters and experiences. From his analysis of Dostoevsky's work, Bakhtin developed the concept of "polyphony" to describe a multi-voiced reality in which the "internally unfinalized consciousnesses" of participants play off each other, co-creating "a genuine polyphony of fully valid voices" (Bakhtin, 1984, p. 6, 176). What is spoken is a response to a previous utterance and, in turn, invites a new utterance to provide an answer. This sequence is never completed as new meanings arise whenever conversations recommence. A similar emphasis on the always-unfinished nature of human experience, and on the co-creativity in "playing off" one another, is to be found in IPS:

> "Much like improvisation in music, IPS is a process of experimentation and co-creation, and assumes we play off each other to create ever more interesting and complex ways of understanding" (Mead, 2010b, p. 1).

In Open Dialogue, this idea of polyphony also draws upon social constructionist ideas of the validity of a plurality of viewpoints and subjectivities, rather than a search for a singular meaning or identity that can shut down or constrain the possibilities open to people. The role of the practitioner is to "guarantee that each voice becomes heard" (Seikkula, 2008, p. 489). The polyphony may comprise both the separate voices of interacting participants in an encounter and also their multiple internal voices or potential subjectivities, voices that may have become suppressed or fractured from one another through experiences of trauma and mental distress, or may simply reflect the more everyday ways in which people bring forward and articulate their different "selves" in relation to the various social contexts that they inhabit (Davies and Harré, 1990; Gergen, 1991).

Less explicit within Open Dialogue are understandings of power and inclusion. Connecting with the later work of Tom Andersen,

Open Dialogue signals a shift from the hierarchical "professional – client" relationship characteristic of much clinical practice (and of earlier versions of systemic family therapy) to a heterarchy (Andersen, 1995, pp. 17–18) in which people and viewpoints are (in theory) seen as equally valid:

> 'Within a "polyphonic conversation," there is space for each voice, thus reducing the gap between the so-called "sick" and "well." The collaborative exchange among all the different voices weaves new, more shared understandings to which everyone contributes an important thread. This results in a common experience which Bakhtin describes as "without rank"' (Olson et al., 2014, p. 5).

However, concepts of heterarchy and "without rank" do not necessarily take account of how perceptions (and realities) of differential statuses within the room are likely to mean than power relations will be enacted, and some voices may potentially be privileged over others. From the perspective of professionals, it may be a challenge to give up positions of "knowing" and "power over" (see Chmnielowska et al., 2022; von Peter et al., 2023).

IPS offers a more overt consideration of power relations as experienced by those experiencing mental health difficulties:

> "In communities of people who have been marginalized, there is an embedded sense of powerlessness that goes unrecognized. Identifying and talking about power dynamics is a beginning step toward breaking them down" (Mead et al., 2001, p. 139).

IPS recognizes "the power of language and labeling practices" in suppressing voices that challenge the dominant status quo of social organization, and how, even within therapeutic situations, there can easily be a re-emergence of oppressive patterns in which "various forms of power are used to blame, control decision-making, and recreate expert/patient type relationships" (Mead and MacNeil, 2014, pp. 3–4). This may be seen to connect with ideas of how the experience of recognition can be fundamental to social justice and emancipation (Fraser, 2000; Honneth, 2004). Being recognized by another person for "who we actually are" can feel profoundly validating and empowering, especially if our own sense of identity may appear a little uncertain or under threat, or in a state of emergence or transition. Conversely, being misrecognized (for example, being identified on the basis of one's diagnosis) may be profoundly disempowering. Peer practitioners may be uniquely positioned to offer such recognition within a process of dialogic interaction and to understand how psychiatric diagnosis and other forms of social labeling can lead to such misrecognition.

In seeking to mobilize shared power through building mutually empowering relationships, IPS connects with feminist understandings of power as developed by Jean Baker Miller and colleagues, and particularly the work of Surrey, who characterized relational strategies of empowerment as involving "a mobilization of the energies, strengths, resources, or powers of each person through a mutual, relational process" (Surrey, 1991, p. 164) – something very different from more individualistic (and masculine-inspired) notions of self-determination or self-actualization. Her description of the operation of such power echoes the emphasis of both IPS and Open Dialogue on the generative nature of the "between" space in relationships and dialogue:

> "The movement of relationship creates an energy, momentum or power that is experienced as beyond the individual, yet available to the individual… Neither person is in control: instead, each is enlarged and feels empowered" (Surrey, 1991, p. 168).

A final area of intersection between the two approaches is a focus on the person in their wider family, social and community contexts. Mead talks about the importance of moving away from unidirectional and dependent "service relationships" (which can characterize many mental health systems) to the reciprocity, the opportunity to give as well as to take, of being a "regular community member":

> "For many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back.. Service relationships are like a one-way street and both people's roles are clearly defined. But in "regular" relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they are offering" (2014, p. 5).

Whereas IPS places the key emphasis on reclaiming reciprocity and mutuality in personal relationships, including the relationship with the peer practitioner where vulnerability can be shared, Open Dialogue focuses more specifically on joining with the person's family and social network itself. Taking a social network perspective is a core and defining principle of Open Dialogue – making sure that someone is not artificially separated from their relational environment but is always seen as a person-in-relationship-with-others. Families, and other key members of a person's social network are always to be invited to the first meetings to mobilize support, not just around the person, but also for other members of the network who may be struggling to understand or deal with what is going on. Beyond this, connection may also be made with other agencies, such as housing or employment, who may be able to play a crucial role in maintaining (or creating) a place for the person in the wider social world.

The areas of commonality and difference in the conceptual underpinnings of Open Dialogue and IPS are summarized in Table 1. From this, it may be seen that, while there are powerful intersections between the conceptual framing of Open Dialogue and IPS, the latter cannot be subsumed into the former. Instead, it has the potential to bring an added conceptual dimension to underpin the practice of peer supported Open Dialogue.

From underpinning concepts to practice principles

Both Open Dialogue and IPS propose principles that seek to define and guide practice, drawing on their respective conceptualizations of the field that have been discussed above. The core ideas that define Open Dialogue practice are articulated within three of the seven Treatment Principles (the other principles, such as the provision of immediate help and psychological continuity, relate to more practical expectations around the organization of systems of care). These Principles are characterized as: a social network perspective; tolerance of uncertainty; and dialogism (Seikkula et al., 2003). IPS proposes

TABLE 1 Open Dialogue and Intentional peer support – commonalities and differences.

	Open Dialogue	Intentional peer support
Authenticity of "I-thou" encounter and the emergence of new experiences and understandings of self and other in the "between" of the encounter	Central idea in conceptualizing the dialogical space in both OD and IPS	
Rejection of pre-planned interventions and solutions	Commonality and congruence between OD and IPS approaches.	
	Tolerance of uncertainty articulated explicitly as a practice principle	Emphasis on shift from *helping* the other to *learning with* the other
Phenomenological concern with questions of language, meaning, and interpretation	Shared emphasis in OD and IPS approaches	
	Emphasis on developing a common verbal language that is inclusive of the ways in which person may be expressing their distress	Need to challenge dominant and oppressive ways by which people may have come to see themselves and their mental distress – including labels and meanings constructed within the system of psychiatric care
Embracing plurality and indeterminacy	Congruence between OD and IPS approaches	
	Polyphony of fully valid voices	Emphasis on opening up the space for multiple truths
Approach to heterarchy and power in therapeutic discourse	Significant differences in how issues of power are addressed	
	Inclusive process in which all participants have a right to speak and be heard "without rank" – heterarchy instead of heterarchy	Greater recognition of embedded powerlessness of people within the discursive context of mental health services. Returning agency to people as a socio-political process based on solidarity, mutual learning and self-disclosure
Social networks and social relationships	Different but complementary emphases	
	Prioritization of including and working with the network rather than the individual in isolation	Emphasis on (re)learning how to do ordinary community relationships based on exchange and reciprocity

principles that shift the focus on to learning (rather than helping); the relationship (rather than the individual); and hope and possibility (rather than fear) (Mead, 2010b, p. 1). Simply amalgamating these does not provide a coherent conceptual basis for Peer supported Open Dialogue – hence the rationale for our discussion with an Action Learning Set of peer practitioners to establish conceptual underpinnings that were grounded in their practice experience and would more clearly define the added value that IPS and the peer role can bring to dialogical practice.

A group of seven peer practitioners from across the ODDESSI research sites came together regularly to participate in an Action Learning Set. This provided an ongoing forum in which peer practitioners and researchers could bring issues and questions for reflective discussion – and for peers to share examples of their practice as a basis for reflective learning. With their agreement, a number of the discussions were recorded. These discussions covered a range of issues and experiences to do with developing and understanding the peer practitioner role in Open Dialogue teams. All of the peer practitioners were trained in Open Dialogue practice and shared some familiarity with IPS. They also brought a variety of experience in relation to peer support and activist roles.

Building on some of the earlier discussions in which peer practitioners had reflected on their use of self within network meetings, we introduced a discussion of "what is different in your way of connecting and being with people experiencing mental distress and family members from how you see other practitioners being with them?" Two sessions of the Action Learning Set focused specifically on what was different and additional that peer involvement could bring to network meetings – and how this might be captured in a set of practice principles. At the background of these discussions were ideas drawn from Open Dialogue and IPS, but, while these suggested some starting points, the main focus was on what emerged in the "between" space as participants shared and made sense of their practice experiences. Although discussions in earlier meetings of the Action Learning Set had tended to focus particularly on issues around self-disclosure, what emerged was a more nuanced sense that this was only one aspect of how peer practitioners might be able to offer something valuable on the basis of their lived experience. The discussion coalesced around certain key ideas which started to delineate the "additional" that peers could bring to network meetings. These suggested a conceptualization of the peer contribution based on the possibilities for *attunement; validation; mutuality and connection*; and *self-disclosure*. In turn, we have sought to translate these, and the reflections on experience of participants, into a set of preliminary principles to guide practice. From the discussions, there was considerable consistency in how understandings of attunement and validation came to be articulated. However, there was more diversity of viewpoints in relation to how mutuality and self-disclosure should be understood and practiced – and this has been reflected in the way that the principles have been formulated.

Attunement

Responding to Seikkula's challenge that "All that is needed is to be present and to guarantee that each voice becomes heard" (Seikkula, 2008, p. 489), peers may have an enhanced ability, based on surviving their own experiences of mental distress, to tune in to experiences that may be particularly hard to voice. As one peer put it, "Your antennae are more sensitive". Attunement may involve picking up on and

responding to a range of non-verbal and linguistic cues: "I do not know if it's eye movement or body language or what it is, but it's quite strange.. But then the language people use as well, I do pick up on that and I cannot work out how other people do not really notice it sometimes". This process of attunement may be seen as generative, one that brings forward new understanding for both parties. This links to Mead's analogy with musicians who can attune to and "play off" one another in an unfolding process of improvisation (Mead, 2010b, p. 1).

Within the wider polyphony of voices in the network meeting, it was felt that "if you have had similar experiences you'll pick up on all sorts of things that others might not notice" – and the importance of self-awareness was recognized in mitigating against the imposition of the peer practitioner's own "agenda" or experience. Prior experience of acute distress could make peers both more sensitive to pain and distress in the room, and also less likely to avoid it: "I think maybe I'm quite good at tuning into that pain, I can just relate to the pain and distress and maybe I'm less keen to cover it up… I'm curious about it".

This enhanced ability to attune may go wider than simply picking up on what may seem personally familiar or resonant. Peer experience can give a heightened ability to sense and connect with feelings even when the actual content of experience may be very different: "I can really tune into the mum even though I have not had a child with psychosis I can just really feel it somehow." Being attuned can mean responding to cues to bring network members into the dialogue. By tuning in to the mother's previously hidden voice in this way, "the mother and son began to then talk for the first time about stuff that had not been addressed but was clearly important." An enhanced ability to attune may not just apply in relation to connecting with a particular person; it may also apply to "reading a room" for signals of the not yet spoken – which can add "an extra dimension in terms of understanding what's happening in the wider group, as well as what may be the voices in that individual."

From this discussion, we propose the following articulation of a new Practice Principle for Peer Practitioners which provides an initial characterization of what may be possible through attunement:

> Through their personal lived experience, peer practitioners can bring a particular attunement to the emotions of others in the room, as well as a developed sense of awareness of, and sensitivity to, the implicit and explicit language that they may be using.

Validation

Seikkula and Olson (2003) highlight the isolation and hermeneutic exclusion of people experiencing their own unique manifestations of mental distress for which they have no language – and hence having only very limited possibilities for this experience to be recognized or understood by others. Buber uses the term "confirmation" to describe a process in which our own unique subjectivity (and humanity) can only be actualized when it is accurately mirrored, and returned to us, through our encounter with another person – an inherently reciprocal process in which the other person allows themselves to be open to receive our confirmation of their unique and present subjectivity. Connecting more with the social action agenda of IPS, such "confirmation" may also be viewed in terms of recognition as a step toward the attainment of social justice (Fraser, 2000; Honneth, 2004) – a struggle that may be taking place within a wider context of potential stigma, oppression and misrecognition, both by the mental health system and wider society. As one peer practitioner put it, "it's just like communities of people who have shared experience who do not start from a place of disbelief".

By virtue of their own lived experiences of mental distress, and perhaps also their own experiences of invalidation and misrecognition, peer practitioners are uniquely positioned in terms of being able to offer a mirroring that can affirm that the experiences of the person or network member are real, and that they deserve to be acknowledged. They can be sensitized to the potential inimical effects of certain psychiatric practices (such as diagnosis) on recognition and validation: "when you do not look at that … you meet the person that you are asked to work with, it's strange." Unusual experiences associated with psychosis can be understood and normalized, rather than pathologized: "sometimes it's the way we connect that makes people feel what they are going through is real." By their very presence, and the potential grounding of reflections in their own experience, peer practitioners may be more able to assure the person that their voice is legitimate and credible. If people feel safe and supported to speak, they may share experiences they have never expressed before. In particular, peer practitioners can be in the position to hear and acknowledge people's extremes of anguish or despair: "recognizing somebody's hopelessness [can be] very validating – you are actually validating who they are rather than who the [mental health services] would like them to be". Some people take longer than others to navigate their personal journey, while others do not change. Peer practitioners can provide legitimation that where people are can be "a valid place to be, like it's okay". Paradoxically, by taking away the pressure to get better in response to the expectations of others, such validation may give people power and ownership in relation to their experience – a sense of empowerment which, in turn, can form a foundation for recovery (Leamy et al., 2011).

For someone who may be struggling with a multiplicity of internal voices or conflicting emotions, it may be important not just that they feel validated as a person, but also that "the polyphony of the voices all talking together" is also recognized as valid and important. This can be the start of a process of "enabling people to start feeling that they can talk about these things, which I think has been really important about normalizing it and maybe taking away some of the stigma." Again, it can be the lived experience of the peer practitioner that offers a particular ability to be "at ease" with the different elements of a fractured subjectivity – and a recognition that it is only through being able to put these elements out into the open in a safe and validating space that the complexity of their distress can be fully heard and acknowledged. By offering such recognition, peer practitioners establish connections that in some way alleviate pain and isolation or engender hope: "there's a kind of magic where you do actually feel once you say it and express it and the other person hears it, it does actually slightly leave you, do you know what I mean? It's quite strange." In turn, this can then provide the opportunity for a process of healing and reintegration – no longer having to hide these elements in an internal world of terrifying isolation, but instead receiving validation, potentially not just from a peer practitioner, but also from those in their network that matter to them. It is through facilitating this wider process that Peer-supported Open Dialogue can create "a space for them to be in the world as a valid person" – something that may be seen as a cornerstone for recovery (Bradshaw et al., 2007).

Another aspect of validation that can be important can be where people have felt that their experiences have been invalidated, not just by people in their family or social networks, or by wider social attitudes, but by mental health services themselves: "it becomes very difficult to talk about the harm that has been experienced by those systems if it's not going to be at all validated by anyone around me." This difficulty in speaking out and being heard about the harm caused by systems may be an ongoing issue, not just for people receiving services but also for peer practitioners working in such services.

Building on these emerging insights, we propose the following conceptualization of validation as a second Practice Principle for Peer-supported Open Dialogue:

> By explicitly and implicitly using their lived experience, peer practitioners can validate and provide recognition for the current experience of people who may be facing misrecognition by others, or coming to doubt the validity of their thoughts and feelings. In turn this can offer empowerment and engender hope by enabling people to reclaim their sense of self-worth and self-belief.

Connection and mutuality

Peer practitioners are perhaps uniquely positioned to understand the nature (and challenge) of connecting when one party is experiencing mental distress. As one peer practitioner put it, connecting can be more "spontaneous" and "instinctive": "…there can be no hard or fast rules and if you think about rules…It's not going to be authentic, it's not going to be spontaneous." This may more easily enable a "here and now interaction" (Galbusera and Kyleso, 2017, p. 3), in contrast to clinical practitioners whose openness to make such an intensely personal connection may be more constrained by "baggage" in terms of role expectations and previous training in relation to professional boundaries. The risk of connecting may also be perceived differently by the person experiencing mental distress, if the person who is seeking to connect with them is already perceived as someone who might know and understand some of their vulnerability. It is therefore possible that the immediate "getting to know" can be framed within a mutuality of risk taking – hence making it easier to build trust.

Their experience may afford peer practitioners a greater awareness that connection requires time and space – in contrast to more traditional clinical practice which can be characterized by controlling interactions and faster treatment trajectories: "I think with some [clinical] practitioners just to sort of like get it done, you know, sort of move on." Such a professionally driven urge to act contrasts with the key Open Dialogue practice principle of tolerance of uncertainty (Seikkula et al., 2003), and peer practitioners may find it easier simply to "be with" and build a deeper trust rather than (however unconsciously) push for solutions. Because of their own experience of "being with" their own distress, peer practitioners may be better able to "be with" a person in acute distress and less afraid to connect with them in that space: "you could be more…comfortable being with someone who's quite acutely stressed because you have been there, and you have survived it… Whereas others that maybe had not experienced that intensity of the stress themselves were just more scared of it." In this way, the presence of a peer co-worker in a network meeting may, in itself, offer permission to clinicians to leave behind this aspect of their background and hence be better able to stay with distress rather than seek to cure it.

Although there are no formal rules for connection, it can be important for peer practitioners to be at the first Network Meeting where the initial connection can be made with the person at time of crisis: "I've felt the most connection with people where I've been invited right at the beginning of the crisis, and I'm kept within that network." Galbusera and Kyleso (2017) emphasise the importance of the core organizational principle of psychological continuity, "which means that the responsibility for the client's health care rests with the same reference professionals for the duration of the whole treatment" (p. 2).

For the peer practitioner, shared experiences of social oppression can result in connection through a sense of solidarity: "it might not be called that in the room … but for me, that's a sense of like political consciousness, like a connection of solidarity of oppression." Humor can be a way of connecting around (and resisting the negative impacts) of such experiences – including those linked to their receipt of services: "Sometimes I feel connected in a slightly mocking position of services in connection with the person, in a sense of like a slightly shared smile." While peer practitioners are often aware of the tensions with their own position as paid workers, they are not bound by the same statutory responsibilities as their clinical practitioner counterparts. This may allow for greater openness to connection and developing relationships based on a greater similarity in their experiences of the operation of power: "I do not think any peer workers have any statutory responsibility around incarceration or sectioning or anything like that I think affects the ability to be with… that allows me a certain level of proximity to somebody that they cannot do."

When connection happens the energy between the people in the room can shift: "there's almost a tangible change in the energy environment in the room when there's a real connection between the person with lived experience and the person in distress at that time." Connection can happen through empathy and shared feeling which can also affect other Network members: "I think there's a huge amount about feeling the pain but also having the empathy. And having been there and felt it I think it's a strong connection to some of the network members." The feeling of connecting itself can be difficult for peer practitioners to describe but words like "magic", "chemistry" and "uncanny" seemed to fit for them. Seikkula observes that in dialogue, "living persons emerge in real contact with each other … without controlling and deliberating on their behavior in words" (Seikkula, 2011, p. 186). Peer practitioners can give insight into this deeper experience of connecting: "So, it's the non-verbal utterances and sometimes we do not even have to say what we are feeling or what we are experiencing or what we are connecting with".

Although strongly emphasized in IPS, ideas around mutuality and equality of exchange do not always fit easily with the peer practitioner role in Open Dialogue – and this emerged as an area of potential tension and dissonance for the peer practitioners. As one put it, "the mutuality thing, I think gets used in the way that we talk about Open Dialogue quite a lot. I feel like – I do not know, I feel conflicted about it". Another voiced their concern in more political terms:

"For me, 'mutuality' means social change because then you actually are helping each other and there's some kind of change happening and there's a sense of solidarity and building and changing.

For me, that's why it can never be a social movement because it's not actually mutuality, we are a health provider."

Others articulated a sense in which both peer practitioner, and the person with whom they were connecting, could both be moved in a real way by the other: "It's also connecting with the experience of having the experience". This fits with Hartmut Rosa's conception of "relations of relatedness" which are characterized by a resonance in which, "in the course of a given interaction, [people] are touched or affected by an Other or by others and, moreover are themselves capable of touching or affecting others" (Rosa, 2019, p. 179). As another peer practitioner put it, they would be open to personal learning "from what I can see or the person tells me". This sense of being moved by (and learning with) the person connects both with a key principle of IPS and with Galbusera and Kyleso's articulation of a "responsive response" in which the practitioner does not disappear as a subject in the dialogic encounter: "Listening and acknowledging the other person are not merely about recognizing the other in the sense of passive witnessing but about what we might call with-ness, the readiness of stepping together into the interaction" (Galbusera and Kyleso, 2017, pp. 5–6). It involves feeling able to bring one's whole personhood (and not just some construction of a professional self) into the interaction. Although practitioners from professional backgrounds also report how they have been moved in dialogic encounters (Taylor et al., 2023), such an ability to "step together" into a space of shared learning may come a little more easily when entering the interaction from the orientation of peer rather than professional. However, the presence of a peer as co-worker may also enable clinical practitioners to take the risk of bringing more of their whole personhood into the interactional space.

We propose, as the third Practice principle, the following characterization of the approach to connection and mutuality that peer practitioners can bring:

> Drawing upon their personal experience, peer practitioners can connect with a person and members of their network by being open to a more mutual relationship in which they can share how they themselves are moved by the emotions and experiences that are expressed. In doing so, they can show how there is no need to be afraid of intense emotions, and thereby keep the focus on connecting and being with people in their experience, rather than reaching for solutions. This may help to build a supportive "between" space in which people can find their own ways of moving forward.

Self-disclosure

Self-disclosure is not a new concept to Open Dialogue, and some practitioners may choose to share life experiences during a network meeting. This is mirrored in Peer supported Open dialogue, which encourages practitioners from all disciplines, to share life experiences, when they feel it is safe, helpful and appropriate to do so within a therapeutic meeting. Such an approach is reflected in Jourard's broader "self-disclosure" theory where the therapist "checks this [self-disclosure] by common sense and judgment, and he limits it to an openness of himself *in that moment*" (Friedman, 1985, p. 10). In practice, while there are studies on the benefits and challenges of self-disclosure from professionals (Knox et al., 1997; Hill et al., 2018), for many staff within statutory mental health settings, self-disclosure is a new concept and approach. With the number of people employed to use their personal experience as an explicit part of their role is growing, self-disclosure is becoming increasingly visible in health care settings (Ahluwalia, 2018; Byrne et al., 2022).

Within the context of Open Dialogue, peer practitioners felt self-disclosure could have a powerful impact in network meetings. As one practitioner reflected "I think the more concerned we get with 'should I or should not I disclose' and all of that, it stops us from being fully human, fully authentic, and effective." Another peer reflected "It seems like almost that just happened in that conversation, someone's experience really relating to someone else's experience." Peer practitioners described using their intuition and discernment before choosing to self-disclose directly in a network meeting or as part of a reflecting conversation with a colleague. One peer practitioner commented "There might be things that I might to say, but in Open Dialogue, it's also about discernment. What would be helpful to share now? And if something has actually triggered me to do with my own lived experience, I guess I go back to a reflection."

The presence of peer workers in mental health teams can create a culture in which staff may feel safe and empowered to share their lived experience and actively use this within their own practice (Byrne et al., 2022). When self-disclosure is used responsively and appropriately, it can encourage others present in the meeting to share personal experiences (Truong et al., 2019). One peer practitioner reflected 'I felt just recently that when I disclose, sometimes it's in a reflection and the other practitioner will immediately say, "yes, I've got that experience as well"… I think they really do want to talk about their own experience and its sort of like opened it up'.

However, any moves toward self-disclosure may be taking place within a pre-existing culture in which upholding personal boundaries was seen as a cornerstone of professional practice. This may explain why, in some cases, peer practitioners noticed mixed responses from colleagues when they self-disclosed in a network meeting. One peer practitioner shared "We have a valid, kind of almost overt part to use our lived experience. I think a lot of the confusion and fear is because you divulge stuff instinctively in the meeting. Very often I've seen colleagues looking uncomfortable." Within a working context in which self-disclosure did not always feel supported, another peer practitioner had chosen to become more reticent about offering this: "When I first started, I did try and bring in more self-disclosure. I do not so much now, I think because it does get latched on to and I think I've noticed it does change things quite a lot".

While the value of self-disclosure was widely acknowledged by the peer practitioners, the emotional cost to the person disclosing was also apparent: "It's the level of self-disclosure and the emotional energy it takes and what it takes out of you". Another reflected, "Most of the time it has a really good outcome. But you absorb all of that and it drains you completely". However, one peer identified disclosing in a supportive space can reduce emotional toil "I did not feel exhausted sharing in that space, it was a really supportive space."

What is apparent, is that the process of self-disclosure is complex and nuanced. Self-disclosure brings a level of vulnerability to the person disclosing and they need to consider their emotional safety as well as the safety of others in the room. The orientation of co-workers can make a difference whether the

TABLE 2 Four practice principles that develop a conceptualization of the additional contribution that peer practitioners can bring to Open Dialogue.

Attunement	Through their personal lived experience, peer practitioners can bring a particular attunement to the emotions of others in the room, as well as a developed sense of awareness of, and sensitivity to, the implicit and explicit language that they may be using.
Validation	By explicitly and implicitly using their lived experience, peer practitioners can validate and provide recognition for the current experience of people who may be facing misrecognition by others, or coming to doubt the validity of their thoughts and feelings. In turn this can offer empowerment by enabling people to reclaim their sense of self-worth and self-belief.
Connection and Mutuality	Drawing upon their personal experience, peer practitioners can connect with a person and members of their network by being open to a more mutual relationship in which they can share how they themselves are moved by the emotions and experiences that are expressed. In doing so, they can show how there is no need to be afraid of intense emotions, and thereby keep the focus on connecting and being with people in their experience, rather than reaching for solutions. This may help to build a supportive 'between' space in which people can find their own ways of moving forward.
Self-disclosure	The title of peer practitioner already constitutes a level of self-disclosure, indicating that a person has their own experience of mental health difficulties alongside wider life experience. In network meetings, peer practitioners should use their discernment and intuition to assess whether self-disclosure would or would not be helpful in supporting or bringing out other voices in the room – and should only do this when they feel it is safe and helpful in doing so.

peer practitioner may feel safe enough to disclose or not. Self-disclosure is proposed as a fourth Practice Principle for peer practitioners in Open Dialogue:

> The title of peer practitioner already constitutes a level of self-disclosure, indicating that a person has their own experience of mental health difficulties alongside wider life experience. In network meetings, peer practitioners should use their discernment and intuition to assess whether self-disclosure would or would not be helpful in supporting or bringing out other voices in the room – and should only do this when they feel it is safe and helpful in doing so.

Conclusion

This paper offers a conceptual framework organized around a set of practice principles to underpin Peer supported Open Dialogue (see Table 2). These principles have been developed out of discussions with peer practitioners working in Open Dialogue teams located in ODDESSI trial sites in England and are grounded in their practice experience. In their paper exploring peer support and shared decision making in Open Dialogue, Chmnielowska et al. (2022) argue that "clarifying the core values and principles of the PSW [peer support worker] in OD [Open Dialogue] will ensure that, as peer support grows, it grows with integrity…" (p. 4). Here we offer a basis for the further exploration of a set of core principles. The four practice principles presented here - attunement, validation, connection and mutuality, and self-disclosure – may be seen to build on core ideas inherent in IPS and Open Dialogue.

A clearer conceptualization of the nature of the peer contribution may be seen as crucial in development of Open Dialogue services where currently the specific challenges and opportunities associated with the peer role may not be well understood – both by peers themselves and by professional colleagues and services more widely. For peers, the proposed principles provide a clearer articulation of what they may be able to bring to a network meeting on the basis of their lived experience. These may be particularly useful in training and supervision, so as to maintain and enhance the integrity of the role. They may also be important in providing role clarity within clinical teams and improving collaboration with colleagues. A clearer articulation of the peer contribution also has implications for recruitment and role specification – and there would seem to be a strong argument that the enhanced opportunities for dialogical connection that peers can bring should be made much more widely and consistently available across services.

Having lived experience of emotional or mental distress can mean greater tolerance of uncertainty, a readiness to navigate the complexity of distress or unusual experiences and perhaps more confidence in "being with" and connecting in a way that offers more of an experience of mutuality, rather than an (unspoken) sense that it remains the duty of professional practitioners to implement solutions for and on behalf of people. However, this conceptualization illuminates how the potentially greater use of self may have implications in terms of sustaining longer term wellbeing. This requires consideration of what Scott (2011) calls "love labor", which can both be intensely rewarding, but can also be emotionally challenging – and hence the importance of tailoring opportunities for supervision and intervision that provide peer practitioners with a safe and protected reflectional space. Perhaps most of all, it provides a basis for recognition by professional colleagues of what, more specifically, peer practitioners may be able to bring to dialogic encounters – and the possibilities that this may open up. Currently there can be contradictory expectations within services that, on the one hand, public self-disclosure may be seen as an expectation of the role while, simultaneously, professional colleagues may show discomfort with the practice as it may challenge their understandings of professional boundaries. These principles provide a broader basis for understanding the range of "added value" that lived experience can bring, in terms of an enhanced ability to offer attunement, validation and mutuality in connection, while emphasizing that they may need to use both intuition and discernment in order to judge when and how self-disclosure may free up or facilitate the dialogue in the room. These principles may also be of value to practitioners from professional backgrounds in providing a framework within which they could also feel more confident in giving and sharing of themselves, and drawing on their own lived experience of challenge or distress. There is a need to work with all Open Dialogue practitioners to further understand how self-disclosure and vulnerability are experienced, so guidelines for navigation can be co-produced.

The translation of these principles into mainstream therapeutic practice may be challenging as they can run counter to many conventional mental health practices and a dominant biomedical culture. Peer practitioners work within a system that may have caused them harm and their experiences need to be recognized and validated.

As the value and contribution of the peer practitioner in Open Dialogue becomes better understood and appreciated, the possibility of gradual, transformational change opens up. Peer practitioners can help provide impetus for a cultural shift within their team that, in turn, can impact on the wider service. Acting as co-facilitators with clinical colleagues, they can create a space where different ways of "being with", validating and normalizing can be witnessed by colleagues and model ways to hear, acknowledge and respond to the voice of distress.

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Introducing Peer-supported Open Dialogue in changing mental health care

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The need to transform mental health care toward person-centered, recovery-based, and network-oriented care is recognized worldwide. Open Dialogue (OD) is seen as a hopeful approach in the context of this transformation and is introduced in countries around the globe. Five Dutch mental health care organizations spread over the Netherlands introduced the Peer-supported Open Dialogue (POD) approach, which adds an explicit role of peer-support workers to the OD approach. It appeared that (P)OD-trained professionals face issues in introducing the (P)OD approach in existing MHC settings. One of the reasons, which is the focus of this study, may be that they encounter difficulties in explaining to non-(P)OD-trained professionals what (P)OD entails. The main objective of this study is to provide guidance to and contribute to making (P)OD better understandable for non-(P)OD-trained professionals. In this study, we used a qualitative design and conducted 23 semi-structured interviews with POD-trained professionals with various backgrounds, to cultivate a rich understanding of which aspects could contribute to a better understanding of POD for non-POD-trained professionals. We used a hybrid approach to analyze the data, meaning that the technique of both inductive and deductive thematic analyses has been applied. From these analyses, six aspects emerged that could give guidance to and contribute to making (P)OD more understandable for non-(P)OD-trained professionals: (1) Experiencing (P)OD by attending treatment network sessions, (2) a coherent and profound narrative about (P)OD, (3) adjusting terminology to better fit the context, such as the two terms "principles" and "responsibility" in this study, (4) the order in which (P)OD elements are introduced in the narrative, (5) bringing the elements "presence," "reflecting," and "expertise by experience" more to the foreground, and (6) conceptualizing the main elements in a "talking paper." A better understanding of (P)OD might be one of the building blocks for improving (P)OD adoption in existing MHC practices, which are on their way toward person-centered, recovery-based, and network-oriented care.

KEYWORDS

peer-supported open dialogue, mental health care, severe mental illness, transformation, network-oriented approach, recovery-based approach, client-centeredness

1. Introduction

At the moment, the necessary transformation of mental health care (MHC) toward person-centered, recovery-based, and network-oriented care is receiving increasing attention across the globe (Stupak and Dobroczyński, 2021; von Peter et al., 2021; WHO, 2021; Galbusera et al., 2022). This transformation entails a paradigm shift beyond the biopsychosocial model (diagnosis, medication, and symptom reduction) to a more holistic approach including an existential component (van Os et al., 2019; Galbusera et al., 2022) that conceptualizes recovery as a personally unique ongoing process encompassing all aspects of human life and concerned with gradually rehabilitating a sense of agency and meaning in life (Anthony, 1993; Slade et al., 2014). Subsequently, MHC practice should be based on equal collaboration between client, network, and care professionals to promote hope and empower people, shifting the focus from diagnosing and intervening to mobilizing the resources of clients and their closest network ("being with" instead of "doing to" people in distress; Seikkula, 2011; Slade et al., 2014; Schötze, 2015; Stupak and Dobroczyński, 2021; von Peter et al., 2021; WHO, 2021).

Open Dialogue (OD) is seen as a hopeful approach to this necessary transformation (Stupak and Dobroczyński, 2021; von Peter et al., 2021; WHO, 2021). The OD approach already embodies this needed change with its person- and network-oriented and recovery-based philosophy (Lakeman, 2014) and provides promising results in West Lapland (Finland), dealing with a severely acute mental crisis (Seikkula et al., 2006, 2011; Bergström et al., 2018). Seikkula (2003) explains that OD provides a rapid response to the crisis by meeting with the client and their closest network, preferably at people's home, in an open dialogue network session within 24 h after contact. Professionals aim to generate dialogue, to create a new and shared meaning of experiences, and to empower people to take ownership of their desired changes. In addition, Hopfenbeck (2015) describes OD as a value-based practice, since OD explicitly describes its core values, including unconditional warmth, authenticity, and openness. In the literature, the approach is often explained by its seven guiding principles: (1) immediate help, (2) social network perspective, (3) flexibility and mobility, (4) responsibility, (5) psychological continuity, (6) tolerance of uncertainty, and (7) dialogism (e.g., Seikkula et al., 2011).

In this study, we focus on the introduction of the OD approach in a context of changing mental health care toward person-centered, recovery-based, and network-oriented care. In the search for better recovery-oriented care, five Dutch MHC organizations spread throughout the Netherlands introduced the Peer-supported Open Dialogue (POD) approach into daily ambulatory care for people diagnosed with severe mental illness. POD adds an explicit role of peer-support workers to the OD approach (Razzaque and Stockmann, 2016; Bellingham et al., 2018), referring to paid professionals with expertise by experience which means that they deploy experiential knowledge "gained through lived experience of psychological distress" (Bellingham et al., 2018, p. 1575). Moreover, POD embraces the adage "nothing about us, without us" (originating from the recovery movement), referring to the call for transparency (Hopfenbeck, 2015).

Organizations may encounter difficulties in translating a broad vision of a needed change into practice as Johansen et al. (2018) found in their "Expedition to Sustainable Healthcare." This has also proven to be the case for OD. It appeared that OD-trained professionals face issues in introducing the OD approach in existing MHC settings, which complicates the adoption of the OD approach (Ong et al., 2019). Literature shows that to fully embed OD, as an approach that embodies the necessary transformation, the context—the existing MHC system as a whole—needs to change as well (Stupak and Dobroczyński, 2021; Von Peter et al., 2021; WHO, 2021). This requires a genuine understanding of what (P)OD entails, which oftentimes appears in practice to be hindered by the complexity of explaining the concept to non-trained mental healthcare professionals. This may be due to the lack of a widely accepted manual that comprehensively explains how OD is delivered (Buus et al., 2017, 2021; Waters et al., 2021). As a result, OD is often not considered as a new way of care (Søndergaard, 2009). The common and seemingly simple question "what do you do in OD?" from non-OD-trained professionals calls for a complex answer (Ong et al., 2019). This may be related to the question Seikkula (2011) raises: whether the OD approach is "psychotherapy" or a "way of life" (p.179). Ong et al. (2019) suggest reformulating the question to "how do you know that you are dialogic?" (p. 420), which allows room to distinguish between "doing" (psychotherapy) and "being" (way of life) in the answer to the question of what (P)OD entails. When introducing POD into Dutch MHC practice, Dutch POD-trained professionals indeed encountered difficulties in explaining the POD approach in an understandable and integrated manner to other professionals and stakeholders.

The main objective of this study is to provide guidance to and contribute to making (P)OD better understandable for non-(P)OD-trained professionals. A better understanding of (P)OD might be one of the building blocks for improving (P)OD adoption in existing MHC practices, which are on its way toward person-centered, recovery-based, and network-oriented care.

2. Materials and methods

This study was part of a broader study that aims to gain a better understanding of the introduction of POD in the Dutch (MHC) context. In this study, we used a qualitative design and conducted semi-structured in-depth interviews, to cultivate a rich understanding (Baxter and Jack, 2008) of which aspects could contribute to a better understanding of POD for non-POD-trained professionals. We used a hybrid approach to analyze the data, meaning that the technique of both inductive and deductive thematic analyses has been applied (Fereday and Muir-Cochrane,

Abbreviations: POD, Peer-supported open dialogue; OD, Open dialogue; MHC, Mental health care.

2006). This study was approved by the Dutch Ethical Review Board of Tilburg School of Social and Behavioral Sciences, Tilburg University (REF RP195).

2.1. Setting

In 2017 and 2018, POD-trained professionals formed six POD networks spread over the Netherlands and introduced the Peer-supported Open Dialogue (POD) approach in five (MHC) organizations (Table 1). One of these networks turned an ambulatory team into a POD team (MHC organization in the southern part of the Netherlands, province North-Brabant), in which the POD approach and its network sessions were at the core of the care, in which other therapies were provided on demand. In this same organization, there was another POD network, in which POD-trained professionals worked in one ambulatory team together with other non-POD-trained professionals and provided day-to-day regular care. These POD professionals organized POD network treatment sessions on request and in addition to regular care. The other four POD networks were communities of POD professionals: one in the north, two in the center, and one in the southeast of the Netherlands. These POD professionals worked in regular teams spread over their (MHC) organizations and provided regular care with non-POD-trained colleagues. In addition to the day-to-day regular care, these POD professionals were connected within the POD community *via* WhatsApp, in which they organize couples for POD network treatment sessions. These POD sessions were organized on request of and in addition to regular care. The POD professionals delivered care to clients suffering from severe mental illness, who differed with respect to the living situation (at home, at an assisted living facility, temporarily admitted to crisis service) and registered diagnoses (e.g., depression, autism spectrum-, anxiety-, bipolar-, and psychotic disorders). At the point of data collection, over 90 POD-trained professionals have been striving to provide care within the Dutch MHC context based on the POD approach.

2.2. Procedure

2.2.1. Participants

The first author asked the board of the national Dutch POD foundation, represented by the five organizations, to provide a POD-trained contact person for each POD network (six in total). These contact persons had coordinating roles in the implementation of POD and had a representative overview of the specific organization. They introduced the study and researcher to the POD professionals. With the intention to incorporate different perspectives, the researcher asked each contact person to list the names of POD-trained professionals working in their network, who had different professional backgrounds and preferably differed in the extent to which they support the POD approach. The researcher approached four POD-trained professionals per POD network.

Sampling was based on purposive (maximum variation in professional background and attitude toward POD) and convenience approaches (Ritchie et al., 2014). The 24 eligible participants received an information letter with the request to respond within 2 weeks. In case of nonresponse, the researcher sent a reminder, and the contact person contacted the eligible participant. We received a total of 23 eligible participants' signed informed consent, after which the interviews were planned and conducted (Table 1). One eligible participant could not participate due to time constraints in the COVID-19 pandemic period.

TABLE 1 Overview of POD networks and participants' professional background per POD network.

	1. POD team	2. Within one ambulatory team	3. POD community	4. POD Community	5. POD community	6. POD community
5 (MHC) organization in the Netherlands	The MHC organization in the south (province North Brabant)		Organization for guidance on key areas of life, in the center (province Utrecht)	The MHC organization in the center (province Utrecht)	The MHC organization in the southeast (province Limburg)	The MHC organization in the north (province Groningen)
Manager	1	1	2	1		
Principal practitioner: Psychiatrist/ Psychologist/ Nurse specialist	1	1		2	1	2
Peer-Support worker	1		1	1	1	1
Case/career manager	1			1	1	1
Therapist/trainer		2				

All POD-trained participants attended the 1-year postgraduate training entitled "Peer-supported Open Dialogue, Social Network and Relationship Skills" at the Academy of Peer-supported Open Dialogue (APOD) in the United Kingdom, which is a course accredited at an English-speaking University at Post-Graduate Certificate level. The course consisted of four 5-day residential modules. Furthermore, the first author of this paper attended this one-year postgraduate training prior to this study.

2.2.2. Semi-structured interviews

The first author conducted 23 semi-structured interviews for 60–90 min using zoom video conferencing during September and October of 2020. The interviewer showed the seven OD principles (Seikkula et al., 2006) and 12 key elements of Olson et al. (2014) on the screen during the interview. The research team had prepared a number of questions *a priori* for the interviews as an aid memoir for the interviewer, which included questions related to participants' vision of the POD approach, e.g., the appropriateness and innovativeness of the OD principles, the adage "Nothing about me without me," and the role of peer-support workers. For example, related to the first principle, the interviewer asked participants "Could you say something about what you think of the first principle?," "How should the principle be applied according to you?," "Why do you think that this principle is important?," and "How does it match with client's needs?" The participants were encouraged to share their views, regardless of whether they managed to apply them in practice at that time and to speak freely on aspects they considered relevant for the introduction of POD in practice.

2.3. Data analyses

All interviews were audio-recorded with permission of the interviewees, transcribed verbatim, and analyzed with the program Atlas.ti. These interviews were analyzed through Braun and Clarke's six phases of thematic analysis, respectively: familiarizing with the data, coding, generating themes, reviewing themes, defining and naming themes, and producing the report (Braun et al., 2019). Prior knowledge is suspended as much as possible, also known as "bracketing" (Patton, 2014). The analysis was an iterative and reflexive process in which we used a hybrid approach, by using a codebook representing the seven POD principles (Seikkula et al., 2006), expertise by experience, and the adage "Nothing about me without me" (deductive) and adding new codes when encountered inductively as well (Fereday and Muir-Cochrane, 2006). The inductive part was related to both what participants want to communicate about POD and how they can best communicate (meta-communication) to make POD better understandable (Appendix I). During these analyses, we also compared responses between participants with different professional backgrounds and the POD networks to see whether responses were different among the disciplines and POD networks. This turned out not to be the case. Any doubts about the coding were discussed with a second researcher. The analyses were completed when no new themes emerged, and saturation was reached. These analyzes gave us insight into both the common ground for what POD participants found important to explain about POD to non-POD-trained professionals and what aspects they found useful to better explain POD (meta-communication).

3. Results

In this section, we outline the aspects, which emerged from the analysis process, which could contribute to making POD better understandable for non-POD-trained professionals.

3.1. A narrative about POD

Participants reported that both experiencing POD by attending POD network sessions and a narrative about POD as a handhold to explain POD could contribute to a better understanding of POD among non-POD-trained professionals. Interestingly, by reading the transcripts, we found a clear common ground in the individual meaning of (why important) and vision (what is "good care") on the POD approach and what participants considered important ingredients to include in such a narrative for the Dutch context.

> "*One thing that would help enormously is if at some point POD could be properly explained to people who are not POD-trained, so that there is more support, and more understanding of POD. And I think one way to make POD more understanding is if someone just joins a POD network session once. As network. Because I have noticed, for example, that because a colleague had once experienced such a POD session, she was better able to judge later whether a POD session could be useful*" (*POD-trained peer-support worker*).

In such a narrative, participants would consider the following as the main ingredients of POD: the dialogical process (principles "dialogism" and "tolerance of uncertainty"), including the involvement of the network with its multiplicity of perspectives (principle "social network perspective"), and the adage "Nothing about me without me." Furthermore, they would describe the other organizational elements as valuable elements to improve the quality of treatment and to effect change. Moreover, participants would add that the principles of "flexibility and mobility," "responsibility," and "psychological continuity" should not be drawn into the absolute or regarded as limitless.

> "*It's not limitless…And here too, it plays a role again. You can also draw that into absolute, making it impossible to do anything with it*" (*POD-trained manager*)

In addition, participants mentioned that they would adjust the two commonly used terms within the (P)OD approach "responsibility" and "principle" for terms that better fit the Dutch context. First, they explained that the term "responsibility" can be confused with the commonly used term "principal responsibility" within Dutch mental health care, referring to a practitioner who is formally responsible for the treatment. Therefore, participants proposed using the term "involvement" instead. Second, they proposed to use the term "elements" as a more neutral term in Dutch instead of the word "principles," as is the case in the "original" approach. They said that the word "principle" in Dutch can give the impression that it is a matter of principle with an obligatory character, and therefore, the risk of dogma is lurking.

3.2. Coherence and profoundness

Participants expressed that they experience difficulties in explaining the POD approach in a coherent manner and bringing to light the profoundness of the POD approach. By coherence, they meant the interrelatedness of the elements and layering of the approach itself. By profoundness, they meant the underlying theories and history of the approach and the notion that POD goes beyond learning new skills (the "doing" of dialogism) and also involves a personal change in the vision, values, and attitude of the professionals (the "being" of dialogism).

They said that when telling non-POD professionals about POD, they often use the seven (P)OD principles to explain what one is doing in POD because it provides a practical framework. However, they notice that it is not immediately obvious that (P)OD is based on certain values and entails a certain culture. They also explained that if you do not manage, in such a narrative, to convey this complexity to non-POD-trained professionals, misconceptions quickly arise. Their suggestion for a narrative would, therefore, be to also explain why something is done in a certain way.

> "*There is such a deep great history, and there are actually all kinds of deliberate forms of therapies underlying it, but you do not see it directly in the principles. I also find that difficult when you explain what Open Dialogue is and you use the seven principles to make it clear that it is not just a conversational technique that you also learn in a course…Maybe that is what I miss in the POD principles, that POD requires another culture*" (*POD-trained principal practitioner*).

> *"POD is of course a way of working, but it is not just a technique. It is a complete change of your whole being. As a human. So it has not only changed me in my work, but also in my general balance, being and contact and in terms of resilience…it really changed and helped me very positively, and I had not thought of that beforehand and did not expect it*" (*POD-trained case manager*).

These findings brought to light that the introduction of (P)OD to non-(P)OD-trained professionals summing up the seven (P)OD principles may not be enough to show the coherence within and profoundness of the (P)OD approach. In addition, three meta-communicative aspects emerged from the data analyses that might help to emphasize in such a narrative the coherence and profoundness of the (P)OD approach, to make it better understandable for non-(P)OD-trained professionals: (1) the order in which (P)OD elements are introduced in the narrative, (2) putting the elements "presence," "reflecting," and "expertise by experience" more to the foreground, and (3) conceptualizing the main elements in a "talking paper."

3.2.1. The order in which POD elements are introduced

In telling non-POD professionals about POD, participants tended to start by explaining the organizational elements, with the result that non-POD-trained professionals often stated that they already work that way. Therefore, participants considered it helpful to start a narrative by explaining the innovative core aspects of (P)OD followed by organizational elements.

> "*Because when people talk about POD, the 7 principles are often used, but there is still a whole layer underneath. And if you only name those seven principles, you may interpret them completely differently because you interpret from a different starting point. That is of course what often happens now, when we talk about POD somewhere. That people often say that they already do that. And sometimes I can imagine that people say that, but then I still think, no! Your starting point is different*" (*POD-trained manager*).

Therefore, participants suggested that in such a narrative it matters in which order (P)OD elements are introduced and they proposed to: (1) start with the underlying theories and paradigm shift (the "why"), (2) continue with the adage "Nothing about me without me" (the "doing"), (3) explain the required attitude (the "being"), (4) elaborate on the required skills (the "being" and "the doing"), and finally (5) describe how to involve the network in combination with the other organizational principles (the "doing"). For each of these four parts, we elaborate on what participants considered important ingredients to explain in the Dutch context:

3.2.1.1. Underlying theories and paradigm shift

The participants suggested that it is important to explicitly explain the underlying theories and paradigm shift (the "why") that are new for non-(P)OD-trained professionals. Therefore, they suggested for the Dutch context to describe in such a narrative the underlying view of the (P)OD approach on mental problems, namely as a resonance in the interpersonal. They would describe

in such a narrative that the problem underneath the request for help should be seen as a shared interactional problem instead of an individual problem. Additionally, they would explain that these problems are often related to a lack of connectedness and language, as a result of things that are difficult to say aloud.

> "*Psychiatric…or problems are never problems of one individual. It is always a resonance in the interpersonal. There is always a network involved*" (*POD-trained principal practitioner*).

> "*because you are never alone in a crisis. It is always an interaction with your environment. With involving the network you already take so much burden away from the person who can no longer bear it*" (*POD-trained peer-support worker*).

Another foundation they considered relevant to mention is that no one has a monopoly on the truth and to explain that truth is based on a shared meaning where everyone's voice is equally important. By this, they would refer to the theory of social constructionism and the importance of polyphony. They would add that the source of both the underlying problem and the power to recover lies within the client and their network. They considered this foundation helpful to explain why they find it fundamental to collaborate with the client and their network, to (re)connect with and between the network members and to find shared meaning, instead of involving the network as a resource group to "solve problems."

> "*And which is really different. Very often in the past you have been approached as a network to solve other people's problems. And POD is not about helping the other, it's about everyone sitting there*" (*POD-trained manager*).

Participants conceived starting such a narrative with these foundations as important to clarify the rationale behind the proposition that connection and insights rather than consensus and solutions are considered the driving force behind change. Participants foresaw that this proposition entails a fundamental shift in Dutch mental health care since society expects mental health care to solve problems and current Dutch mental health care is also set up this way at the moment.

> "*There are expectations from the mental health care that problems will be solved so that you no longer suffer from those problems, and that is not how POD is set up*" (*POD-trained principal practitioner*).

3.2.1.2. The adage "Nothing about me without me"

The participants expressed that these underlying foundations and fundamental changes are embodied by and become tangible through the adage 'Nothing about me without me'. Moreover, they said that this adage adds shared sense-making to the already familiar concept of shared decision-making, which ensures that the narrative would fit in with a concept that is already known. Therefore, they suggested continuing such a narrative with this adage because it could help to understand the implication ('the doing') of these fundamentals, e.g., abolition of multidisciplinary consultations.

> "*If you would apply the adage for 100%, I have often said, you radically change mental health care. The 'Nothing about me without me' adage helps enormously to continuously involve people because you need them*" (POD-trained manager).

3.2.1.3. The required attitude

According to POD professionals, such a narrative should then go into the basic attitude of (P)OD (the "being") because it says something about what the foundations and adage imply for the professional himself and the way they connect and interact with the other. They used words such as "humble attitude," "dropping the professional mask," the importance of "unlearning," and "the courage to be vulnerable in your profession."

> "*It's not about them, it's about us. If you want to change mental health care, you should not change the clients, but you will have to change the way you approach them. And that change is up to us. And the POD training provided for that*" (*POD-trained manager*).

In describing this basic attitude, participants would explain what is meant with and emphasize the importance of being authentic, present, and open in contact ("being with" instead of "doing to" people in distress). According to participants, this could help to explain to non-(P)OD-trained professionals how to shift from intervening expert to participating human being with experience and expertise. Participants would also describe the notion of unconditional warmth, referring to compassion and a full unconditional appreciation of the other because it differs from the common notion of distance and proximity.

> "*There are many implicit assumptions about how to do POD right. 'Sitting with the family' is a baseline for whether you have worked the POD way: have I really been there, have I really sat down next to people. Presence is the essence*" (*POD-trained principal practitioner*).

3.2.1.4. The required skills

As a next theme, participants would elaborate on the required skills. They expected that these skills give an answer to the 'doing' of (P)OD and could show non-(P)OD professionals how to enhance connectedness between the client and their network and to create space in which hidden insights are given room to be unraveled (also called the unspoken). Participants found that the (P)OD elements dialogism and tolerating uncertainty best describe the needed core skills of professionals and that these skills belong together as reciprocal conditions.

With regard to dialogism, participants said this element could help to explain why and how to shift from a solution-oriented

perspective to a relation-oriented perspective with polyphony as a core concept. They would explain that professionals' prior focus should be on establishing connectedness and creating a safe culture of sharing. Additionally, they would explain that in order to do this, professionals need to be fully present and responsive to what is happening at the time, rather than having their own or preset agenda and taking the lead.

> "*…because that's where we catch ourselves time and again: we are or remain a kind of detective in the mystery of that misery that is presented. You want to know things as care professionals: how did it come about. You may be curious about what is happening and certainly you may ask to say a little more about what someone is saying, but you are responding to what is being said, and you are not looking for new information. You leave that detective role and step into the in-depth role*" (*POD-trained principal practitioner*).

In addition, participants would emphasize in a narrative that dialogism is also an end to foster dialogue between people, empower people, and effect change. So that it becomes clear that the shift from "doing" to "being" is not the same as doing nothing, which participants said was sometimes the concern of non-POD-trained professionals. Therefore, in a narrative, they would underline the importance of not taking too little responsibility in contributing to change under the guise of following the pace of the process, tolerance of uncertainty, and the not knowing. That is, professionals should take responsibility to assume their role in the dialogical process: listening to each other and mutual sharing during reflecting moments. They would add that the extent of sharing and the boundary of tolerating uncertainty are personally and contextually determined, that this is a timing matter and that finding this balance is a personal process.

> "*For example, I admire Seikkula, who sits on the edge of his seat leaning forward toward people. I think that's wonderful and I can sit like this, but I cannot react like him. When Kurti talks, I think 'wow', that is a lot of energy and she also shares personal things. Whereas, Jaakko never speaks about himself. And so we all have something good. And we should use that for God's sake. You have to. So it has to be internalized and not become a trick (POD-trained principal practitioner).*"

Moreover, participants found it important that in such a narrative tolerating uncertainty is properly explained because this element shows the paradoxical approach of POD, and it gives guidance to non-POD-trained professionals on how to provide recovery-oriented care. They found that this element helps to explain how professionals, instead of trying to solve the problem, can better align to the clients' and networks' pace in the process, respond to and reflect on utterances of each person and create space so that client and network can take responsibility in their own recovery process. In doing so, often the solutions in the form of insights come naturally from the client and her/his network.

In addition, participants would highlight in a narrative the skill reflecting to explain dialogism and tolerating uncertainty to non-trained-POD professionals because this skill is more tangible and already common. They would then elaborate on the so-called reflection moment (referring to sharing reflections with a colleague in the presence of the client and network during a network session), which they considered innovative for the Dutch context. They found it important that the narrative includes an explanation of how to disclose appropriately (from the POD perspective). They would add that, with unconditional appreciation as a basic attitude, this would imply that professionals reflect on what resonates and emerges in them, allowing themselves to be affected more and share more personal experiences from an authentic vulnerability than professionals educated with distance and proximity might be used to.

> "*Sharing (personal) things requires a certain authenticity, a certain modesty, a certain vulnerability, which is not easy for everyone. So even if people want to share that, do you dare to say that? Do you dare to be vulnerable, in your profession? And I mean really genuinely vulnerable*" (*POD-trained peer-support worker*).

> "*There was a discussion about professional contact and POD contact. But I am a very professional POD'er, also just a person with experiences in life, which can be both part of the dialogue if they are at the service of the dialogue. Then I find that very professional*" (*POD-trained casemanager*).

3.2.1.5. Involvement of the network in combination with the other organizational principles

Participants would end such a narrative with a description of the organizational (P)OD elements in which they would view the facilitation of the network sessions with (at least) two POD-trained professionals as the backbone of the treatment process, in which all necessary therapies can be integrated. In this part, they would describe the reasoning behind the notion to involve the client's closest network from the beginning on. They would refer to, e.g., developing a well-established therapeutic relationship, broadening everyone's perspective on the situation, supporting and engaging the network, and smoothing the process of getting back to life without getting bogged down in old patterns again. In this context of creating a safe collaborative culture, participants would explicitly mention the value of peer-support workers. They found that peer-support workers are often very sensitive and adept at bringing out the unspoken, putting it in words, and making people feel heard and seen.

> *"The peer-support worker, I work with… I find that every time a gift to facilitate network sessions with her. She always knows how to press the right buttons, where I theoretically feel there is something there, but she does that so beautifully because she can*

> *also place her own emotional experience in it. They naturally get the role of a 'confidant' pretty quickly and that's very nice"* (*POD-trained principal practitioner*).

Finally, to explicitly show (P)OD's need-adapted philosophy, participants would explain the elements "flexibility and mobility," "responsibility/involvement," and "psychological continuity" similar to the original OD approach. With regard to flexibility, participants would explicitly stress the importance of being flexible related to time (duration and frequency) and content of the session, without being limitless (90 min on average). They would explain when the time for a session is too limited as they were used to, it is challenging to get out of the "chak-chak-chak-mode," and professionals will tend to reach for solutions, may be more formal, more directing, and monological in contact. In terms of frequency, they would explain in such a narrative that at the end of a treatment session, it is determined through shared decision-making if and when the next meeting will take place instead of automatically scheduling sessions.

3.2.2. Putting "presence," "reflecting," and "expertise by experience" more to the foreground

So, in addition to introducing the (P)OD elements in a certain order in a narrative, participants would also bring three elements more to the foreground in their communication about (P)OD: "presence," "reflecting," and "expertise by experience." They suggested that the elements "presence" and "reflecting" should be brought to the foreground to give more meaning to the term dialogism. Moreover, participants said that these terms are familiar to non-(P)OD-trained professionals and may, therefore, help them to gain a better picture of what is meant and needed to be dialogical. They expected that this could help non-(P)OD-trained professionals to differentiate between dialogism and having a dialogue with someone, as we all engage in conversation with one another.

> *"So dialogue as a word, as an element, has little appeal to the imagination. We all do, don't we? And that's right. Only within the Open Dialogue does it have its own meaning. Can't we grasp that in that principle? The answer is probably no. And then 'reflection' is also an important word. To make the attitude explicit."* (*POD-trained principal practitioner*).

Furthermore, they would propose to use the term "expertise by experience" in a narrative to express the role of peer-supported workers and the importance of the professional skill to share experiences in a proper way as peer humans, which applies to all professionals. The latter is the reason that participants would propose the term "expertise by experience" instead of "peer-support workers" in a narrative about POD because they suggested focusing on the expertise and not the expert role. However, they would position the element "expertise by experience" as an organizational element in this stage of development because they believed that in the current context the desired position of "peer-support workers" within treatment teams is not yet self-evident and needs to be organized.

3.2.3. Conceptualizing the main elements

Finally, to show the coherence and profoundness of such a narrative, participants considered a visual "talking paper" helpful to make (P)OD better understandable for non-(P)OD-trained professionals. They would use such a "talking paper" as a communication aid to untangle, illuminate, and delve into the key elements of the POD approach, without losing sight of the coherence and profoundness of POD (the "being" and the "doing"). They suggest not only listing the elements but also visualizing the elements in an interrelated (coherence) layered (profoundness) constellation. (P)OD professionals could then talk through layer by layer in the order that they suggested for a narrative. In practice, participants emphasized that the appearance of and relationships between the (P)OD elements are not linear or disentangleable and that such a "talking paper" similar to a narrative could change over time.

> *"I think then, assemble the big picture"* (*POD-trained principal practitioner*).

> *"I think those seven principles are preconditions, while those three core elements about attitude, that's actually how you should be as a human being. That goes deeper. But I do not know why it's been pulled apart like that"* (*POD-trained manager*).

4. Discussion

The main objective of this study is to provide guidance to and contribute to making (P)OD better understandable for non-(P)OD-trained professionals. There is rich literature about the OD approach and its underlying foundations (e.g., Seikkula and Trimble, 2005; Seikkula and Arnkil, 2006; Seikkula, 2019). In addition, studies refer to the potential risks of misconceptions about OD (e.g., Søndergaard, 2009; Ong et al., 2019; Waters et al., 2021), which is also recognized in practice. However, little is known about how (P)OD professionals can best explain the approach in practice to non-(P)OD-trained professionals to increase the understanding of (P)OD.

We found six aspects that could provide guidance to and contribute to making (P)OD more understandable for non-(P)OD-trained professionals: (1) Experiencing (P)OD by attending treatment network sessions, (2) a coherent and profound narrative about (P)OD, (3) adjusting terminology to better fit the context, such as the two terms "principles" and "responsibility" in this study, (4) the order in which (P)OD elements are introduced in the narrative, (5) bringing the elements "presence," "reflecting,"

and "expertise by experience" more to the foreground, and (6) conceptualizing the main elements in a "talking paper."

One of the main suggestions in this study is that it can be helpful to consciously introduce the (P)OD elements in a certain sequence, in order to make (P)OD more understandable: starting with the underlying theories and fundamental view on mental health problems, continuing with the adage "Nothing about me without me," followed by the required attitudes and skills, and finally the involvement of the network in combination with the other organizational elements. The POD professionals in this study indicated that it is tempting to use the seven OD principles as a quick start guide to introduce the POD approach to non-POD-trained professionals since it makes the profound multilayered approach more tangible and demarcated. Literature shows that these principles have been used to evaluate OD practices as well (Waters et al., 2021). However, the developers of the principles classified the principles as guidelines and did not intend to define OD (Seikkula and Arnkil, 2006). Similarly, using this list of principles as a backbone to explain (P)OD may not do justice to the coherence and profoundness of the approach. Consistent with Ong et al. (2019), the results of this study show that in order to make (P)OD better understandable a narrative about (P)OD would need to touch upon both the deeper layer (the "why" and the "being") and the practical side (the "doing") of (P)OD.

This study proposes to start such a (P)OD narrative by explaining its underlying theories and fundamental different view on mental health problems. (P)OD addresses the question of the etiology of mental disorders. Seikkula (2019) proposes that the human mind could be viewed as relational and subsequently, human behavior could be considered as part of the responsive relational context instead of attributed to a single person. Following this line of thinking, Stupak and Dobroczyński (2021) describe in their study that psychiatric disorders could be seen as a primary consequence of living conditions and their significance for individuals. Without delving into a discussion about which etiological view on mental disorders is the right one, continuing the (P)OD philosophy, opens new perspectives and leads to different questions, e.g., "what is wrong with you?" shifts to "what's happened to you?" (Longden, 2013). Like in the metaphor that mankind once believed in the flat Earth model, their belief in a spherical Earth led to different questions and made questions such as "how far do I sail before I fall off the earth?" redundant (Bill, 2001). In other words, one can see the parallel that fundamental changes in thinking about our existence lead to new perspectives, different lenses to look through, and a set of new questions.

As non-(P)OD-trained professionals look through these new lenses, it may be clearer that the collaborative nature of (P)OD sheds new light on network-oriented care. Seikkula (2021) suggests that the novelty of the current MHC context may be that this therapeutic relationship and the importance of connecting and reconnecting people is not an aspecific factor within POD, as it is usually considered, but could be seen as the specific working factor of the approach. Understanding the "earth-is-round" suggestion of shifting from a solution-oriented perspective to a relation-oriented perspective could help to understand why POD's primary intention is to connect and re-connect through a mutual process of uttering and responding, meaning, and understanding and giving words to the unspoken, without striving for consensus (Seikkula and Trimble, 2005). In addition, it may become clearer for non-POD-trained professionals that the approach requires a fundamental change of the professional him/herself, by turning from an expert trying to solve an issue or crisis (do to) to a human sitting with the client and his/her closest network (being with) and foster dialogue (Seikkula and Trimble, 2005). In a similar vein, the closest network is also not involved to solve something. This shift may help professionals to profoundly understand how recovery-oriented care can be put into practice (Damsgaard and Angel, 2021) and confirms the importance of the therapeutic relationship, connectedness, and integration, which is broadly considered crucial (van Os et al., 2019; Seikkula, 2021; Finsrud et al., 2022).

This study proposes to continue such a narrative with the adage "Nothing about me without me" as a tangible statement, which could be seen—from a POD perspective—as an embodiment of the "earth-is-round" fundamental for the current MHC context. For example, this adage takes shared decision-making, which is being pursued in current practice, to a higher level by extending it to shared meaning-making and shared decision-making (von Peter et al., 2019). This adage also demonstrates that an "earth-is-round" way of thinking can imply a radical reshaping of the current MHC, which is in line with the study of Beeker et al. (2021). That is, if this adage is fully applied, the consequence could be for example that multidisciplinary consultations behind closed doors are abolished.

This study suggests continuing, after this adage, with the required values, attitude, and skills because the associated elements relate to the dialogical mindset (Ong and Buus, 2021). Subsequently, after setting the scene by introducing first the "earth-is-round" fundamentals from a (P)OD perspective and this dialogical mindset, the other organizational elements are put forward. By introducing the central elements in this order, the organizational elements are considered through these new lenses instead of from the traditional point of view. This can help non-(P)OD-trained professionals differentiate the (P)OD approach from other integrated care models with familiar organizational elements (Von Peter et al., 2021). This order in introducing (P)OD elements differs from most literature on the POD approach, where the organizational elements are often presented first, and then it becomes clear in the explanation of the approach that the dialogical process is central (e.g., Seikkula et al., 2003; Seikkula and Trimble, 2005; Olson et al., 2014; Razzaque and Stockmann, 2016; Seikkula, 2021).

However, leaving the organizational elements until the last part of such a (P)OD narrative may also involve a risk of misconceptions. As Von Peter and Zinkler (2021) refer in their paper, there is a risk that others may believe that (P)OD is possible without realizing institutional reorganization and a risk that (P)OD may be used as a cloak to cover the current symptom

reduction based system, without fundamentally changing it. Furthermore, Beeker et al. (2021) state that (P)OD requires a radical reshaping of the current MHC. This study suggests explaining, in such a narrative, how (some) organizational elements should be seen as prerequisites to do full justice to the adage, required attitude, and skills. However, it is still a risk to be aware of. Moreover, Ong et al. (2019) describe in their paper that these organizational elements can be seen as "operational" elements and can also help explain how one can know whether someone is "doing" POD. This could be another reason not to make the sharing of organizational elements in a POD narrative too small.

In line with the literature, the results of this study suggest that explaining the (P)OD approach only partly or fragmented in separate elements may result in a lack of genuine understanding of the (P)OD approach and dilute the uniqueness and innovativeness of the (P)OD approach (Søndergaard, 2009; Seikkula, 2021; Waters et al., 2021). For example, studies illustrated that the term dialogism is often reduced by professionals working within the existing MHC system to a communicative function, lacking the creative collaborative reciprocal act of finding new meanings and the notion of "being dialogical" (Seikkula and Trimble, 2005; Ong et al., 2019; Seikkula, 2021). This was also found in this study, which led to the suggestion to bring the elements "presence" and "reflecting" to the foreground, to give more meaning to the term dialogism. In addition, this study suggests conceptualizing the (P)OD approach in a "talking paper" to help to see fragments in coherence and as a backbone for a (P)OD narrative. This "talking paper" could be seen as a visual metaphor that presents several core elements in a layered interactively integrated constellation, rather than in a list (e.g., Seikkula et al., 2006; Olson et al., 2014; Razzaque and Stockmann, 2016). Such a visual metaphor could show in which order the elements can be best introduced in a (P)OD narrative and emphasize that these elements are mutually connected and entail both the "being" and the "doing."

We hope that these six aspects give guidance to and contribute to making (P)OD more understandable for non-(P)OD-trained professionals. In doing so, we hope that this better understanding might be one of the building blocks for improving (P)OD adoption in existing MHC practices, which are on their way toward person-centered, recovery-based, and network-oriented care.

4.1. Study limitations and future research

We acknowledge that the study also has a number of caveats. One relates to the sampling, in which care was taken to include multiple perspectives of the POD-trained professionals to gain a rich view. However, we only took into account different professional backgrounds and their attitude on (P)OD. Other possible influencing factors were not taken into account, e.g., level of communication skills, degree of experience with applying (P)OD, or communicating about (P)OD. In addition, none of the participants was decidedly negative in their vision of POD. This may have skewed our participants' view on what is needed to make (P)OD better understandable. Furthermore, the consequences of the COVID-19 pandemic may have influenced the choice of eligible POD professionals to participate in this study.

Moreover, these six aspects to provide guidance to and contribute to making (P)OD better understandable may be context-dependent. For example, the order in which the elements can best be introduced in the narrative can differ per context. If, for example, in a context the notions of involving the network, visiting clients in the home situation, or staying involved are new, it might be needed to introduce these elements earlier in the narrative than portrayed in this study, which took place in the Dutch context.

Furthermore, the aim of this study was to provide guidance to and contribute to making (P)OD better understandable for non-POD-trained professionals. However, the saying 'it takes two to tango' applies also to making (P)OD better understandable. In this study, we have only included the perspective of POD professionals. Whether the found aspects can truly contribute to making (P)OD better understandable should also be viewed from the perspective of non-POD-trained professionals. An example of an aspect that might be difficult for (P)OD professionals to judge is whether the language they use is attuned to the context. Moreover, the way it will be perceived may also be influenced by the tone of voice and the manner in which the message is conveyed by the (P)OD-trained professional. Introducing such a transformative philosophy requires an understanding, attentive, and careful approach. The (P)OD approach may provide guidance on how to convey the POD approach to non-POD-trained professionals. Analogous to the transformative dialogue with clients and the network during treatment sessions, POD professionals could entice non-POD-trained professionals to join in a creative collaborative reciprocal act of finding new meanings. First, the POD professional would then aim to connect with colleagues by being responsive to the utterances of the non-POD professional, and second, to gradually introduce the POD philosophy in an active participatory manner. Being dialogical could help to carefully consider the socio-cultural fit to local conditions (Buus et al., 2017) by being adaptable and responsive to the needs of the current MHC context (Ong et al., 2019).

The next valuable step after this study may be to evaluate with non-(P)OD-trained professionals whether and how the six aspects improve the understanding of (P)OD among non-(P)OD-trained professionals. The moment that (P)OD is better understood, the question will rise whether this better understanding indeed leads to greater support for (P)OD and to better adoption. Because even when (P)OD is fully understood and embraced, applying it in practice is another matter and requires nuance, timing, and balancing. For example, professionals should not draw the elements of the (P)OD

narrative in absolute, which may be the risk of trying to capture (P)OD in a compact, comprehensive, and demarcated (P)OD narrative, just as Waters et al. (2021) refer to the risk of manualization of (P)OD. In practice, the appearance of and relationships between the (P)OD elements are not linear or sequential and disentangleable. For example, in applying (P)OD in practice, practitioners may encounter a continuous tension between two stances: one is the tendency to be humble and adapt to others' needs and the other one is the importance of taking an active participating role in the reciprocal dialogical process. These conflicting needs do not need to be mutually exclusive but do require continuous balancing (Galbusera and Kyselo, 2019). This relates to the statement that a person-centered approach is per definition an interperson-centered and dialogical approach (Galbusera et al., 2022). This brings us back to the underlying POD notion that all voices equally matter (Seikkula and Trimble, 2005). So, it would be interesting to gain insight into other prerequisites – besides a better understanding—to further adopt and subsequently embed the approach in a changing (MHC) context toward person-centered, recovery-based, and community-oriented care.

Even though there are still questions to be tackled on the road to broader adoption of (P)OD, starting with making the POD approach better understandable for non-(P)OD-trained professionals, could be the first step to facilitating an open dialogue about the potentials of this approach within a changing mental health system on its way to (inter)person-centered, recovery-based, and network-oriented care.

Data availability statement

The datasets presented in this article are not readily available because the raw data supporting the conclusions of this article cannot be made completely anonymous. Requests to access the datasets should be directed to KL-A, c.a.g.lorenz@tilburguniversity.edu.

Ethics statement

The studies involving human participants were reviewed and approved by Ethical Review Board of Tilburg School of Social and Behavioral Sciences, Tilburg University (REF RP195). The patients/participants provided their written informed consent to participate in this study.

Author contributions

KL-A, JB, and IB: conceptualization and methodology, and writing, reviewing, and editing. KL-A: thematic analysis and writing the original draft preparation. KL-A and JB: analysis and interpretation of results and project administration. JB and IB: supervision. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2022.1056071/full#supplementary-material

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Training in Open Dialogue and Dialogical Practice: creatively responding as trainers and writers

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This paper emerges from a series of conversations about training in Open Dialogue and dialogical practice. In our dialogue, we found ourselves moving away from seeking definitive answers about content (what to include) or process (how to include). We asked, "Why are we asking this question about training at all?" Maybe it is because many helpers and all kinds of professionals all over the world are truly asking, "How do we do, or how do we learn how to do 'open dialogue'?." That question starts with "How to train others in the practice?"

We moved toward responding to our own questions—what are we offering as trainers and what are the trainees seeking? We sought to explore what is required for a training space that accommodates the hopes of both trainers and trainees. Words arose during our talking, and we listened to them, let them sink in, and reflected on them. Some words resonated with us as trainers; some linked with observing trainees' experiences (including our own); some showed a glimpse of the relationship between trainer and trainees. These emergent words point to a series of learnings, aspects of the training that we as trainers have come to believe are important. The following paper expands upon these words while also including actual portions of our dialogues and vignettes from training. As such, we illustrate our ongoing learning as trainers of Open Dialogue and dialogical practice as it occurs within the unique nature of each training we provide.

KEYWORDS

Open Dialogue, training, dialogical practice, dialogical process, reflective supervision, embodiment, open dialogue training, dialogical training

Introduction

Hello and welcome to our article, which will explore our experiences and discussions about being trainers in Open Dialogue and dialogical practice in our four different countries and contexts. What is the history of how we came to be writing this article? At the start of the pandemic, a group of women came together to support one another as writers. We met online monthly, with our first challenge being to find times when meeting from our different time zones in Finland, the United Kingdom, the United States, and Australia would be possible. With some compromise, early morning for some and late evening for others, we managed it. Through the months, our connection deepened as we came to our meetings with no agenda. We just listened and were heard. To see and to be seen kept us returning. From this space, ideas emerged. Over time, we had used the space to talk about our different training experiences, so when the

invitation to write for this journal arrived, we were all keen to write together. In the spirit of dialogical practice, we want to be transparent about what we are inviting you into. In essence, we are exploring the qualities and processes that are part of dialogical practice and training. Primarily, our focus is on how to "be", less so on how to "do".

Open Dialogue as an approach is a model and frame for organizing mental health services. There is a global shift in thinking, in which people are exploring the contribution of Open Dialogue and dialogical practice to mental health services. Questions around training are present, and different training programs are being developed. As increasing numbers of people are thinking about these issues, it makes sense that there are still many open questions about skills and insights regarding the Open Dialogue system of care and dialogical practice. These questions arise when designing an adequate training program.

In writing this paper, we offer our contribution to this conversation. Open Dialogue is a paradigm shift in mental health, from an expert and set agenda about symptom reduction, to a dialogical focus on relationships, understandings, and stories. Our writing reflects this shift. As such, our process here mirrors a dialogical way of working, whether as a therapist in network meetings, a supervisor, or a trainer. Although we could describe this work as part (poly)-auto-ethnography and part perspective, the dialogical nature of its methodology may suggest that this work is unfinished, akin to the unfinalizability of network meetings. In taking a 'not knowing' approach (Anderson and Goolishian, 1992) to stay curious, we privileged listening and responding over the certainty of theory or a predetermined destination. As with network meetings, we aimed to be in the present moment with the writing as it unfolded, to listen and to respond to what emerged from each of us, to privilege our relationship with each other, and to bring more of ourselves to the writing. We sought to stay with our differing voices, feelings, and emotions and held space for silences between and within our meetings. We sought to honor the emergence of the many voices within each of us, as with network meetings. In the writing, we trusted in the dialogue and in the dialogical process.

We invite you into this dialogue, into trusting in the dialogical process, where perhaps there are times when there is no clear concept of where it is going. Just like at the start of any dialogical training session or network meeting we ask, "What would you like to talk about today?" As with dialogical practice and training, we are not aiming for a set response from you but for as many different responses as there are readers. To quote from the chapter named, "Creativity in the whole life" in a special section, "Dialogue and Culture", "...it must be stressed that what follows is not given in the spirit of a prescription that society follow. Rather it is an invitation to the reader to begin to investigate and explore in the spirit of free play of ideas and without the restriction of the absolute necessity of any final goal or aim" (Bohm and Peat, 1987). Perhaps it would be helpful to take a moment and consider how you are entering this space. What might be your curiosities and wonderings? What are your feelings? Is there any sensation in your body at the start of this? As you read on, perhaps you will notice how your thoughts, feelings, and bodily sensations move and change in the process.

As you read, you may also notice that some words are in italics. These are words that have stood out for us. They seem to be the qualities that we seek to engender during the differing forms of training that we each offer. Maybe they are also the challenges of training in a dialogical way. So now, we share our reflections with you in this space between our words and your experiences.

Mia's Voice

When I began to attune to this topic, the very first thought for me was the beginning. How do we start the training process? What is there for all of us to think about in terms of creating a fully competent Open Dialogue and Dialogical Practice training program that would *offer* people a suitable framework for learning?

> It is unbelievable how the core *presence* of people is the same all over the world: People want to connect and create dialogical spaces. This helps! (Mia's trainer's notebook, 2017)

People require dialogic skills in their practice when meeting people and networks in distress. How do we design training that supports the learning process which offers trainees the possibility of making the required changes in their practice? How do we invite the trainers and the trainees to a joint journey where knowledge is generated so that trainees may become dialogic practitioners—practitioners who also have the required insight into different levels of Open Dialogue as a practice and/or system of care? There are many questions for trainers to discuss together when planning the process collaboratively. When creating the general frames, it is also important to embrace that every learning process is unique and that *each person needs time and space to find their own way and at their own pace*.

In my experience, the planning of the training program requires consideration of the context of the training. We should *honor the local* prospects in building the frames and circumstances that enable people to have an empowered position in relation to the new approach they are learning about. What are the needs for dialogical training in different organizations around the world? How can we build the *training in a need-adapted manner while respecting the core principles* of an Open Dialogue practice (Seikkula and Alakare, 2004)? When we establish a training program, what are we *inviting* people into? I am wondering if the trainees have enough information about the purpose of training in their context so that they can bring their own needs accordingly. Trainees could be encouraged to ask themselves, 'Are my needs met here and how do I bring my questions to the process?'

I am also carrying my own history and context as a practitioner and trainer coming from Western Lapland, Finland. Open Dialogue and dialogical practice in Western Lapland could not have taken place without extensive training over several years. The practice has been supported by dialogic family and network-based therapy training that has been offered to all the workers in the department of psychiatry and the larger community. Learning through intertwined aspects of theory, supervision, and family of origin processes, people are invited to create a dialogical dimension to their practice. The work has shown that dialogue in network meetings requires *trust* between team members and also a sound understanding of the use of reflective practice to generate insight into the topic and situation at hand. Practitioners also need to be able to *listen* to both outer and inner dialogues when facilitating the meetings. Each participant in the meeting *reflects* the voices of multiple roles, identities, and experiences carried and held within a narrative and a bodily memory (Haarakangas, 1997; Haarakangas et al., 2006). A multifaceted dialogue can arise from these aspects, which can offer crucial new and different insights for participants when the practitioner–trainer has an awareness of their own inner voices, including how these voices emerge in their professional role at any moment.

One perspective that I feel is crucial is that trainers need to have the experience of being with people in mental distress and *bodily knowing* about the nature of processes (Lyons-Ruth, 1998; Shotter, 2011). This can help them generate self-agency in the trainee's learning process (Rautkallio, 2019). The main goal for me is that in the end, it is the process, and the trainees in it who have been making the process, and trainers have the privilege to witness (i.e., "with"-ness) it.

Alita's Voice

What is open dialogue training? Sometimes, I wonder, is "training" the right word? What do others think when they hear the words "open dialogue"? Is it a "thing" they hope to "implement" or to change others with somehow? The ways of learning information in chunks and bits of formulaic knowledge, historically fed to us by the powers that be, are changing. Embodied, implicit knowing, or dialogical knowing is a bit different (Lyons-Ruth, 1998; Brown, 2015). If or when a facilitator, trainer, or teacher can engender a space where trainees are invited to move more toward that embodied, implicit, or dialogical moment and maybe a bit away from the formulaic, perhaps dialogism begins. What I mean to say is that there are bodies in a room together, whether in a treatment meeting or a training/learning environment, and these bodies come with implicit knowledge. How do they know what they know? And can we as trainers per se ask ourselves whether we are acting on or initiating movement toward or away from the co-knowing that might be coming from the "meeting" of the other bodies in the room? There are these moving-toward and moving-away movements happening all along. Are we attending to these?

> On its way to the ocean, is the river's edge where the bravest of settlers surrenders into the way.
>
> What is going on in our waters? What is happening in our world? What can be learned of it in partnership, in collaboration that can never be learned in hierarchy …
>
> Pause
>
> (On Its Way … by Alita Taylor)

One thing that keeps pressing upon me at different times while pondering questions about dialogical training spaces is "Who trains?" What about the trainer? Are they humble, open, and trustworthy? Do they actually care about their trainees? How do they feel right now, right here in the moment with me? Will they be honest? Are they wanting to help me "get" something that they wish I would "get" but have not yet? Who are the ones who can teach us something? What are the ways in which we are teachable, and what are the ways that teachers or trainers themselves stay present, compassionate, and loving? Are they hungry? And are they open to all the ingredients here in the room to make a sort of soup of learning together?

How do we train? Taking together our own preparedness of material (e.g., psychodynamic and systemically-based exercises, family-of-origin and supervision homework brought to life in a reflective process facilitated by the trainer, impromptu role-plays), we cannot forget to ask trainees throughout training days, "How would you like to use this space today?" We negotiate together about how to use the space and trainers co-construct a safe space. But what is a safe dialogical space (Simon, 2023)? We cannot know this without curiosity and asking and listening to those in the room. The question is: What happens to the space when it is not negotiated beforehand or when one or more voices are more powerful? What is that like for the trainers and the trainees? What is coming up for the trainees? Making enough space available for exploring and struggling together. Trainers participate as *containers*, *holding space*, having the willingness to share the space, practicing co-regulation. We check in together. "How is this for you in this present moment?" Wondering together is a creative process in the here and now within any given moment in any given role-play or other reflective training exercise together.

Dialogism is like being with a child. Waiting and stopping, not saying everything on our mind. Allowing time for digesting, listening to the meaning-making, like making a recipe with your hands, not with imitation butter flavor, but being in the flow, wondering, asking without expectation of a certain answer, without a "right way", trusting the agency of the organizing happening in the here and now. Trusting in the agency of the organism, in all the beings in the here and now in this new meeting or training in which all are participating, of which all matter. How to "elegantly order" the voices, the bodies housing the voices, the helpers near and far, engaging, and realizing the contexts? How uncertainty can be a bridge, a common grief expressed, a holding environment, like the improvisation of a dog playing in the water.

We aim to be *invitational* in the exercises we offer, and we try to remember our power as trainers and how hard it might be to decline invitations. The depth and topic of sharing are up to the trainee in any given exercise. We also aim to give space and time for everyone to *reflect on bodily, emotional, and cognitive responses* and to process these as individuals and within groups. One such important training practice is called the Wheel of Awareness (Siegel, 2018), in which individuals and groups can practice all the different ways one can be aware. These positionalities can be developed and can bring the right hemisphere ways of knowing to the fore. *Giving space and time* to the process of what is to be learned together is imperative. It can not be and is not the same every time. There are always new moments and new thoughts to be shared and responded to Cunliffe and Lock, 2020. The "how" we train is inside us. It is in how we see and respond to what is happening and in how we collaborate with others in that space to talk (Anderson, 2014). Wondering together and leaving room. Being willing and able to let go of fixed positions, opening to the free play of thought in a spirit of goodwill and friendship, ready to acknowledge any fact and any point of view as it actually is—this generates a dialogical culture in training spaces (Bohm and Peat, 1987).

Cathy's Voice

I am on the telephone, listening, and talking with a person (who we might call the person who accesses services) and another person (who we might call a colleague). That said, by being dialogical, these positions do not feel so rigidly defined. We share what is on our minds, and what we are sitting with, and sometimes sit in silence as thoughts and feelings and bodily sensations arise in the space. I am moved by what is shared and by what I learn about myself. I feel my thoughts and ideas expanding. The "person who accesses services" says that we should call this way of working, "loving and nurturing".

I am now in a new country, having arrived at 2:00 a.m. It is incredibly hot. Walking to the venue where we will be training, I have

tears in my eyes. *We bring all of ourselves* to the training. My heart is full. My colleague begins the training day by talking about her mixed connections to the country. She has brought herself to the space and her own different inner and outer voices. She shares something of her own vulnerability. A safe space feels like it is opening whilst keeping aware of the transient and complex positions of safety in group spaces. In the moment, the trainees experience this and begin to respond with their own feelings and thoughts. In the afternoon, we meet for lunch with a family who we have previously only met online. Meeting them in person, I feel a rush of joy and connection. Love. I am buying drinks, and one of the family members is helping me. The father says, "Your brother is helping you to buy tea." This resonates with us all.

The family has agreed to join the training. They sit in an inner circle with me and another Open Dialogue trainer. We have both facilitated previous network meetings with the family online. The trainees sit in an outer circle around us. We had previously agreed with the family to all speak about the family's experience of the meetings rather than having a live network meeting. Today, the family is discussing having a network meeting. I am more hesitant, since the family has only just met the training group and am *transparent* about this and we enter *not knowing*. The family members begin by talking about their experience of the meetings, how they work and how they feel.

> "We are just asked what we want to talk about."
>
> "The practitioners speak about what they are feeling together so that we can hear it."
>
> "It is like sitting with family."
>
> "We don't feel judged."
>
> "We all feel listened to."

Then one of the members of the family begins to speak about something he had done that he was troubled by. It seems that a safe enough space has been created for him to bring his own vulnerability here and feel brave enough speak of it. Those of us in the inner and outer circles lean in attentively as the family speaks together about this. The pace is slow, and there are a lot of silences. Tears are shed from people in the inner and outer circles. It is hard to put into words but it feels like time has slowed down and that there is a feeling of connection and love in the space between us all.

After the meeting, the family and the trainers who have met with the family go to a local cafe together whilst the other trainers and trainees pick postcards with different images to write a few words to the family about what has moved them. Before leaving, the family speaks informally to the other trainers and trainees. More heartfelt connections and sharing take place. One of the trainees stands as the family exits as a mark of gratitude to the family.

We had all taken the journey together, with *both the trainers and trainees contributing to creating an embodied sense of safety and love in the room* (Seikkula and Trimble, 2005). In addition to direct teaching on *how* to coordinate a network meeting, the trainees expressed that they felt an understanding of what it was like to be part of one. The next day, my colleague and I spoke about our experience of the meeting in a reflective supervision space. We sometimes call this "intervision" because of its *flatter hierarchy*. We invited three trainees to listen and to be part of a reflecting team. We spoke, not about the content of the meeting, but about ourselves and what came up for us. More tears were shed. In the spirit of dialogical practice, the reflecting team in their supervision space spoke of their connections to our words and did not interpret, offer solutions, or advice. One trainee said that she felt envious that we had a space like this where we could *trust one another enough to share our vulnerabilities.* Another trainee said that they now knew how dialogical practice felt, adding that nothing had really changed in their understanding, but that something had shifted for them.

Judith's Voice

> Years ago I bought a card from one of my special places in the world, with the words 'To discover the ocean, one must first lose sight of the shore'. Indeed. My exploration of dialogical practice has led me into learning and training and learning and…and so it goes on, continuing to beckon me...into that ocean. The early mixture of both fear and excitement has calmed over time, yet the dialogical process continues to surprise me….

We are on the third day of a 4-day introductory training in Open Dialogue and dialogical practice. Most trainees in the group have ostensibly settled into the shift away from didactic training, toward a dialogical training experience with *a focus on both content and process*. Since the first day, I have been aware of an older man sitting in the circle of chairs, at ten o'clock to my six o'clock position in the circle. I have a sense that he is less engaged with the training, less engaged with the group, and less engaged with me. I have wondered if perhaps he has been told to attend, or perhaps it is related to my gender, age, or professional discipline. When he directs questions at me, I metaphorically and actually lean into the space between him and I, *to stay with*—yet not be overcome by—his presence.

And on the third day, a question emerges, not from the older man I had been aware of, but from another in the circle. "But you need to tell us how to do Open Dialogue." Once it is voiced, everyone seems to breathe out. I encourage the trainees to remain in the unknowing and lack of definition for now. I *encourage* them to trust that a training process that remains congruent with a dialogical way of working—a dialogical way of being—will bear fruit. This response seems to settle the group. Or perhaps the voicing of the question has already done so.

On the following day, the last of the training, there is a calmness in the space...as usual. Everyone seems settled, including the older man. He approaches me before leaving. Something in him—and in me too—has shifted. It is *a sense, an inner knowing*. It is as if we have come full circle now, together. I have *hope and trust in the dialogical process* of training yet again, but what happens is still a surprise.

These moments bring to mind the need to touch on the nuanced experiences of previous training—to trust in the dialogical process. Whether in training, supervision, or clinical work, it has taught me to trust that each person in the room is experiencing their own process, while also experiencing a group process. As a dialogical practitioner, trainer, or supervisor, the *dialogical process in the group is for me to manage, but the process for each individual is theirs alone.* This is most apparent in the refrain that has emerged in every 4-day Introduction to Open Dialogue and dialogical practice training. It is the moment of the question asked by trainees: "Tell us what to do. How do we do Open Dialogue?"

In past trainings, this question often remains unspoken until the third day, to be released, or perhaps it escapes with the momentum of sitting for days with uncertainty. Often, it emerges from one trainee, before it echoes elsewhere around the circle. In dialogical training, such a question opens the possibility for trainees to experience trusting in the ever-emerging dialogical processes within the group, and within themselves. It seeks a trainer's response of holding steady, *showing rather than telling*. For both trainees and trainers, the question invites everyone to *wait for the learning to emerge*, as befits their way of learning, their way of being. The question is part of the training process. As is the response.

In trusting in the dialogical process of training, a dialogical space is created (one could say composed) by, and in the group. In this space, dialogical concepts can be introduced, begin to be processed, and possibly start to be integrated into each individual's practice and way of being. To differing degrees, it is different for everyone. Each trainee gradually learns to be dialogical, in individual and group processes. So too, it is for the trainer. Becoming dialogical is unfinalizable, it is never complete (Bakhtin, 1984).

Our Conclusion Is to Pause

Thus, in coming together in a dialogical way, we do not conclude here but come to a pause. We wonder, "Have we used the space to talk about what you wanted to talk about today?" Our writing has been something of a dialogical journey for us, with the ideas and words unfolding as we continued to talk, to listen, to reflect, and to trust that something would emerge. Now we invite you to consider yourself in this dialogical process. What is coming up for you? What are you noticing about yourself? We would like to invite you to take a moment to notice these things … in this moment.

> (On Its Way continued … by Alita Taylor)
>
> On its way to the ocean, is the river's edge where the bravest of settlers surrenders into the way.
>
> What is going on in our waters? What is happening in our world? What can be learned of it in partnership, in collaboration that can never be learned in hierarchy.
>
> Miracles I see in our hands, and with the ones next to us.
>
> Bluer than the sea are our woven sorrows of which we must hold with exquisite care.
>
> Who are the helpers like this? Where are the servants like this, who care enough to reveal the sadness that our psychological, behavioral health interventions have lost their way, who say strongly like the river does—we know not where we are going. We know not tomorrow's weather, but we know we must flow with what is, and fight not the rocks of time. Instead, we collect light, fall free, making whirlpools of wonder, leaving nature's job to all the elements.
>
> We are not visitors, nor individual inventors. We are together in this, beyond science and categories.
>
> We are artists walking around with instruments called bodies with voices, cries, aches and ideas. We shall experience it all with one another because when there is no one there to hear and see another's experiences our Body loses life limb by limb.

At the start we revealed that particular words/concepts italicized throughout were the things which emerged for us as qualities we seek to engender in a dialogical training. The qualities refer to the *being with* throughout training in Open Dialogue and dialogical practice whether in the dialogical family-of-origin/social network exercises, supervision, or theory days of training. They include our desire or intent to honor the local, to be invitational in our offerings, to reflect on bodily, emotional, and cognitive responses, to listen for and remember the not-knowing-ness, to be transparent, to hold dialogical space, to be a container, to give the time and space for each to find their way in their own pace, to attend to the bodily knowing happening, to wait for learning to emerge, to trust one another enough to share our vulnerabilities, both trainers and trainees contributing to creating an embodied sense of safety and love in the room, a flatter hierarchy, hope and trust in the dialogical process, staying-with, bringing all of ourselves, showing rather than telling, encouraging and sensing-into our inner knowing, focusing on both content and process, reflecting and adapting to the ever-changing needs of both trainees and ourselves as trainers seeking to provide the conditions for dialogue.

These are the conditions that we as four women from four different parts of the world seek to provide as we continue to meet online together to support one another's work and lives. During the pandemic, we needed each other, and we continue to do so. We feel the importance of continuing dialogue with other trainers in a safe dialogical space is a necessary part of being dialogue facilitators. We, too, involve ourselves in a process, making ourselves vulnerable, sharing with one another our internal dialogue, our worries and hopes, and the difficulties and the joys of walking the path of a trainer in Open Dialogue and dialogical practice. We alone cannot know what to include, what to exclude, or what curriculum should evolve, or how, but we continue to share our experiences and to be open and creatively responsive to what is needed in the training we offer. What contexts are we bringing ourselves into? Who holds power? Where is our own power in what we are making space for? By continuing to support and hear the struggles and wonders of training experiences, we continue to learn more. We remain in an ongoing process.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Author contributions

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Open Dialogue: A case study on the influence of sharing or withholding reflections during a network meeting

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In Open Dialogue, sharing of reflections by professionals constitutes an important contribution to promoting a polyphonic dialogue between participants. In the inner dialogue, past and future influence the present moment. In this study, we explore the influence of sharing or withholding reflections by professionals on the interplay between inner and outer dialogue. A case study was used with a multi-perspective methodology, which combined video recordings of a network meeting and interviews by using video-stimulated recall with the clients separately, and social workers together afterward. We found that the sharing of reflections by professionals stimulates the inner dialogue and creates an opening for sharing these in the outer dialogue. In addition, we observed that when reflections are withheld, the client's inner dialogue still continues, but their inner dialogue was not shared in the outer dialogue.

KEYWORDS

network meeting, inner outer dialogues, dialogism, reflections, significant and meaningful moments

Introduction

Since January 2015, a transformation in the social domain in the Netherlands has taken place with the introduction of new legislation contained in the Participation Act and the Youth Care and Chronic Care Act (Kelders et al., 2016). This change has affected all aspects of the social domain such as the cutback of financial flows in the healthcare system, but also a shift in the organization of welfare and care from the Dutch government to local authorities and citizens. Self-reliance is promoted, together with informal caregiving from family carers or by volunteers or other important members of the social network (Dekker and Van Dieren, 2016).

This transformation requires social workers to work actively with clients and members of their social network from the onset of care or support. One of the key principles of social work is that the professional actions of the social worker should involve how to coach the client to develop themself in relation to their social environment and within the socio-cultural context (Van der Mei and Luttik, 2018). This is in line with the knowledge and research agenda of social work in the Netherlands, which promotes social network meetings where members of the informal network will actively participate

in the meeting. In recent years, knowledge has been developed about social network approaches and social network reinforcement. But researchers acknowledge that more practice-based knowledge is needed on how to apply informal network approaches in daily life practice (Hooghiemstra et al., 2020).

Recent research work shows that many social workers are reluctant to do so. Most of them confirm the importance of this way of work, but in everyday practice, it is not often operationalised. Previous research shows that many social workers experience:

- Inability to work with the client and their social network because most treatments are individually organized
- Finding attunement care or support is a relational quest and this demands relational and dialogical skills from the social worker
- Feeling insecure due to a lack of knowledge, tools, and training (Van Regenmortel and Lemmens, 2012)
- Organizations promote working with social networks but do not have a vision of how to do so (Dekker and Van Dieren, 2020, 2021).

Our assumption is that Open Dialogue can help professionals conduct network meetings to create space for the participants' worries and needs. It creates a place where all participants will be heard and be together to find new constructive ways of dealing with concerns that can emerge (Seikkula and Arnkil, 2006, 2017).

Dialogue is seen as a way to have a conversation about problems or worries between the client(s) and their social network members in addition to finding a way to acquire more agency in their lives. It is a mutual or shared inquiry of listening (Anderson, 2007), questioning, and reflecting on the problem, to find new ways to go forward. The social worker will respectfully respond to the utterances of the participants and will share their own reflections and invite the others to react—in order to avoid a one-sided context (Olson et al., 2012, 2014; Seikkula and Arnkil, 2017).

A network meeting has three functions, according to Alanen (1997): (1) to gather information about the experienced problem, (2) to create a treatment plan, and (3) to generate dialogue. In the dialogue, the focus will be on strengthening the client's adult side (Seikkula, 2002) and on having a discussion that views the client's behavior as meaningful (Alanen, 1997; Anderson, 2007; Olson et al., 2014; Seikkula and Arnkil, 2017). Dialogue is a relational and collaborative activity (Anderson, 2007). In the dialogical process, different voices emerge. First, there is the horizontal polyphony or outer voices. These are the words spoken by the participants. But there is also a vertical polyphony or inner dialogue present in the dialogue. These are the thoughts and feelings each person has during the meeting that are not yet spoken out loud. In generating dialogue the aim is to create space for "the not yet said" (Anderson and Goolishian, 1988; Rober, 2002). The dialogue comprises not only verbal utterances but includes all responses including (signs of) empathy, compassion, emotions, and bodily changes connected to the process of meaning-making in social interaction (Bertrando and Arcelloni, 2014; Kykyri et al., 2017). All voices or perspectives are equally important and it is important to respond to these as professionals (Seikkula and Arnkil, 2017; Ong and Buus, 2021). In the dialogue, professionals are not seeking agreement about the problem but they invite as many voices or perspectives as possible so that new meanings can emerge (Anderson, 2007; Rober, 2012; Lidbom et al., 2014). From this point of view, you could say that all these utterances occur in the present moment. But in the dialogue, the past resonates, and in the answers, the future can emerge. Thus, in the dialogue, the future can serve as an inspiring viewpoint for creating new meanings, actions, and understandings (Boe et al., 2015; Seikkula and Arnkil, 2017).

During a network meeting, professionals create an opportunity for clients and network members to share reflections while others are listening. In doing so the professionals will look at and talk to each other and not to the family or network about what they have heard during the conversation. During this reflecting process, the professionals will share ideas, images, and metaphors that came to mind during the conversation with the client and family. Andersen (1995) formulated some guidelines regarding procedures for guiding the reflective process. Reflections should be based on what has been said or expressed during the conversation. It is important that the shared reflections are not statements, opinions, or assertions of meaning, but are formulated as ideas or suggestions. Statements and opinions can be easily heard as criticism. Another rule is that the professionals will avoid negative reflections. The professionals are encouraged to use ordinary language, and professional jargon should be avoided (Andersen, 1992, 1995; Olson et al., 2014). Seikkula and Arnkil (2017) state that when professionals are reflecting, others will be present in their inner dialogue by listening. By inviting them to respond to the reflection, a space is created so that they can share their inner dialogues. The goal is to create space for new conversations where new meanings can arise during the network meeting and the participants can find ways to move forward. Sharing reflections may create space for "the not yet said" (Anderson and Goolishian, 1988; Rober, 2002).

In a network meeting, the concepts of sharing reflections, inner and outer dialogue, and time influence the dialogical process.

This study aims to find answers to the following research question: What influence has the sharing or withholding of

reflections by the social workers on the inner and outer dialogue in a network meeting?

Methods

Our assumptions led to a research project in a Youth Care organization on how social workers work together with children/teenagers, parents, and other social network members. In this action-oriented research, we work with professionals who are open to changing the way they work and want to work actively together with the social network (Dekker and Van Dieren, 2020, 2021). In November 2020, the social workers received basic training in the dialogical approach in network meetings. During and after this training, we studied how the dialogical approach can help children, teenagers, parents, social network members, and professionals to find attunement regarding social care or support. As a result of this training, two social workers recorded a network meeting which we used for the case study. One of the social workers is the second author of this article.

In the case study, we explored whether sharing reflections or withholding reflections by the social workers influenced the inner and outer dialogue of all involved.

Inspired by the research work of Rober et al. (2008) and Lidbom et al. (2014), we wanted to explore the dialogical process in a case study by seeing how sharing reflections influenced all those who are involved in the network meeting. This is a qualitative case study of a father and son, who received care after the mother passed away.

The son had entered the local youth care a couple of years earlier, at the age of 15, due to an autistic spectrum disorder. He was referred to a farm care programme one weekend a month to relieve the family and help him learn to deal with his problems. When social worker 1 met the family for the first time, it became clear that more help was needed because of the son's angry outbursts and depressive symptoms. At first, the conversations were only with the son, but early in the process, the social workers decided that it might be helpful to have meetings with the father and the son together.

A year later we recorded one network meeting with the father and the son and two social workers. The actual network meeting was organized by the youth care organization and took place at the father and son's home. The network meeting was recorded and lasted 1 h and 15 min. Before this meeting, social workers had several meetings with the son alone and met four times with the father over a period of 11 months. After recording the network meeting the participants were interviewed afterward by the first author, using the video-stimulated recall method (Rober et al., 2008; Nguyen et al., 2013). To analyse the content of the inner and outer dialogues, the reflections, and the interplay between them, we made use of the dialogical concept of Sullivan for qualitative data analyses. This approach provides tools to analyse subjectivity in qualitative data. "Subjectivity is theorized as changing and responsive to others" (Sullivan, 2012, p. 1). In particular, we made use of the concept of key moments which contain utterances of significance, reflection, and relational impact (Sullivan, 2012, p. 21–23).

During the network meeting, three main topics were discussed. The three topics were the evaluation of how the son was behaving socially, the relationship between the son and the father, and the ending of the support relationship with one of the social workers. The chosen fragments appear in the second part of the conversation.

The first stage of the research was recording the network meeting. The second stage was to watch the recording with the son and the father separately the day after the recording. We asked them to stop the recording at significant moments and to answer the question, "what was on your mind at that moment?" No other questions were prepared for these interviews. The answers were recorded on video. The procedure was repeated with the two social workers together 2 days after the recording, using the same method and asking the same question. This meeting was also video-recorded.

The third stage was to transcribe all the recordings. The fourth stage was to select recording fragments. Only those fragments were selected where all participants stopped the recording and shared their inner thoughts and feelings. Thirteen selections were made and all four participants stopped the recording around the same time and stated these moments to be significant. We did not obtain the exact time of pausing for all four participants. The video was paused with a couple of seconds difference between each participant. It was often shared that they were looking for the right moment to pause and we observed that they all talked about the same topic. Thus, we came close enough to be able to put the selections together. During the next stage (stage five), from those selections, we placed the outer and inner dialogues of all involved in the meeting in the correct position according to the pause they had made in the video recording. In the sixth stage, we looked for the presence and/or withholding of shared reflections in those selected recordings, and we examined what happened in the inner dialogue and what followed after that in the outer dialogue.

From those selected recordings, we chose one fragment that shows the presence of shared reflections and one fragment that shows the absence of shared reflections to build our analysis upon. The first was chosen by the first author as meaningful because of the rich content of the inner dialogue of all participants while the sharing of reflections was absent. The second fragment was selected because the father and son called this a powerful and meaningful moment after a reflection was shared.

TABLE 1 Analysis matrix absence of reflections.

Social worker 1			Social worker 2			Father			Son		
Outer dialogue	Directed at	Inner dialogue	Outer diaogue	Directed at	Inner dialogue	Outer dialogue	Directed at	Inner dialogue	Outer dialogue	Directed to	Inner dialogue
						But what has changed is that – Yes, somehow I notice that he has started to take me a lot into account, in the sense of hey maybe I should stop asking questions in the evening for all kinds of conversations.	All, but especially to the son.				
								Yes, this is where I lose my son somewhere. Every time I think of hey– Well, that's why I was looking for words in the beginning, because before you know it, you'll hit the wrong botton with him while you want to give him a compliment. It just hurt very much. I'll close myself off to you. That is not the case. I found that a really painful moment.	Doesn't necessarily have to do with taken into an account but more with I've given you a shitload of information and now I'm just closing myself off to you.	Son to Father	
		That continues to touch me because somewhere I see how hard father is trying and how much baggage he has and he is also is vulnerable and really tries to be a father. While I can also understand the son very well of all the pain that is in him that he finds this so difficult. And we've talked about that several times.				Ok. I can do that too. I don't think that's true, but if you experience it that way, you may.	Father to Son				

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TABLE 1 (Continued)

Social worker 1			Social worker 2			Father			Son		
Outer dialogue	Directed at	Inner dialogue	Outer diaogue	Directed at	Inner dialogue	Outer dialogue	Directed at	Inner dialogue	Outer dialogue	Directed to	Inner dialogue
			Because what makes you say that? I'm curious?	SW 2 to Son							I was like yes it's fine to park it. SW2 says why are you saying this? I was like yes, I'm really attacking my dad here. I shouldn't have been so attacking. Why did I say this? I actually started to think about that whole choice of why did I say this. Why am I literally trying to hurt my father here? So when SW 1 said do you want to park this? Then I was like– Oh let's park this. Because my father is going to play a role in the rest of my life **and it might also be useful to discuss things like that with my father. Only I have no idea how.** Then I thought I must remember this, I still have to talk about this.
Is it ok to park it for a while?	SW 1 to SW 2	Yes, because you're asking a very good question, right? But I had been here with them before and talked about it and I was thinking is the son going to be central again and then I see father disappear into the background.						And there were all kinds of process interventions here. Well I have just tried to give my son a compliment, but he has rejected it, saying I close myself off to you anyway. Well and that's why I'm now also like how are we going to put this into words? How should			

(Continued)

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TABLE 1 (Continued)

Social worker 1			Social worker 2			Father			Son		
Outer dialogue	Directed at	Inner dialogue	Outer diaogue	Directed at	Inner dialogue	Outer dialogue	Directed at	Inner dialogue	Outer dialogue	Directed to	Inner dialogue
								I do this? And my son who picks that up continuously when I am completely burned out. Yes, then I feel so inadequate.			
			Yes, you may	SW 2 to SW 1	**Well, for me it wasn't when I go to the son that I didn't father– But you start somewhere. So that same question goes up I go back to father.** But you know, I also felt that you want to stop him very consciously so then I'm not going there either– You have that pre-knowledge.						
Because otherwise we go there – I'm very curious what dad– Is that ok for you?	SW 1 to SW 2	Then it will be fifteen minutes longer at least. And I didn't want that. So I thought I just want to stay with dad now. *But I did want to check that with you kind of.*			kind of…						

Red, past; Green, present; Blue, future.
Italics, inner dialogue during primary conversation.
Bold, inner dialogue during reflection in the reconstruction conversation.

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Chosen fragments and analysis

The first fragment: Withholding of sharing reflections

The topic of this fragment was evaluating changes in the relationship between father and son (Table 1).

Outer dialogue

The outer dialogue concerns how the father wanted to compliment the son on how he had changed his behavior. The son's response was offensive to the parent. Social worker 2 (male) asked the son the reason for this response and social worker 1 (female) requested that the question be parked.

Inner dialogue

Social worker 2 asked the question to the son, and social worker 1 wanted to park the question. In the inner dialogue, social worker 1 was afraid that the question would lead to a repetition of the interaction she had experienced in previous meetings with the father and son. Social worker 2 heard the request of social worker 1 to park the question and felt that social worker 1 probably had good reasons for her request, so he agreed.

The inner dialogue of the parent during this fragment was that he wanted to give a compliment to his son. He wanted to tread carefully so that the teenager could accept the compliment. The son's reaction evoked painful feelings of incompetence in the father. In the inner dialogue, the son was wondering why he had this reaction toward his father because the son realized that the relationship with his father will continue one way or another whereas the relationship with the social workers will come to an end.

The interplay between the participants' inner and outer dialogues

The topic during this fragment concerned the progress the son has made in his behavior over the last 11 months. In the inner dialogue, the father was carefully looking for words to express the improvement. In the outer dialogue, the father said *"Yes, somehow I notice that he has started to take me into consideration a lot in the sense of - hey maybe I should stop asking questions in the evening in all kinds of conversations"*. The son reacted "*Doesn't necessarily have to do with taking you into consideration, but more with I gave you a shitload of information and now I'm just close myself off to you"*.

In the outer dialogue, social worker 2 asked *"What makes you say that? I'm just curious?"* Social worker 1 asked social worker 2 "*if it was okay to leave the question for the moment and not go in this direction"*. Social worker two answered, "*That is fine*".

In the inner dialogues, completely different meanings were experienced. Because of earlier experiences of outbursts from his son, the father was careful about what and how to say things and how to give a compliment. In the recall interview, the son explained his reaction toward his father. The question by social worker 2 made the son realize that this way of reacting was "*very offensive*" toward his father. The son was glad that social worker 1 wanted to park the question. In the inner dialogue, the father experienced the reaction of his son as: "*I feel like I'm falling short"*. In the outer dialogue, the father expressed that he doubted if the reaction was genuine, but respected his son's feelings. The father questioned the son's reaction because in everyday life the son's behavior shows something different. After watching this fragment, the son started to reflect on his reaction and started to reconstruct ways to get along with his father in the future. "*I realised I have to deal with this because my father will play a role in my life and SW 1 will be gone from my life*".

In the inner dialogue of social worker 1, the interaction between father and son was experienced differently compared to social worker 2. Social worker 1 did not want to discuss the reasons for the son's reaction toward his father. The reasons not to address the subject were due to earlier experiences with the pair and the hope of giving space to the father to express himself.

In the inner dialogue, social worker 2 was not aware of that and experienced the request (to park the question) as inappropriate, believing that social worker 1 thought that *"if I asked the son this question, it wouldn't invite father to respond. But I felt you wanted to stop him"*. Social worker 2 felt that social worker 1 wanted to stop this interaction and agreed to park the question for the moment because *he felt that she had prior knowledge of the situation*.

Interestingly, it may appear that the dialogical space was closed at the request of social worker 1. But in the inner dialogue between father and son, many things happened. This also makes it clear how important it is to be sensitive toward clients' expressions and to invite them to explore the connected inner dialogue. It also clarifies the fact that earlier experiences can make a social worker hesitant to enter the dialogue on topics that had been discussed in the past (Olson et al., 2012; Seikkula and Arnkil, 2017). Social worker 2 was curious why the son reacted this way and wanted to know how it was experienced by the father as well. In this fragment, the attunement between the two social workers was disturbed, which led to a closure of the outer dialogue.

The second fragment: Withholding of sharing reflections

The topic during this fragment was the relationship between the teenager and the parent (Table 2).

TABLE 2 Analysis matrix sharing of reflections.

Social worker 1			Social worker 2			Father			Son		
Outer dialogue	**Directed at**	**Inner dialogue**	**Outer dialogue**	**Directed at**	**Inner dialogue**	**Outer dialogue**	**Directed at**	**Inner dialogue**	**Outer dialogue**	**Directed to**	**Inner dialogue**
									English humor is the most fun humor, so sometimes I can take it and sometimes I can't. And if I don't handle it then it's very annoying.	Son to SW 1	
Because it also touches you again, do I matter? If I say that so correctly. And if your father sometimes tries to say something positive with some English humor, you feel that tone and that touches you. And that happened again somewhere.	SW 1 to Son							Well he points out so I can handle it. Well that makes it difficult for me to understand it again. Sometimes he can and the other time it can't handle. Because I noticed by myself again the– Yes, you want to defend yourself.			
									What was the trigger, yes, but that's who I am. Easiest excuse ever. Even if you shoot me, I won't get rid of it.	Son to SW 1	
I hear your father searching for where is it that things go wrong because I try to do it right and sometimes I don't quite get it. But I don't know if that's true?	SW to Father & Son										
						In my experience, but maybe I am wrong, but can you basically handle it. We also have fun together about crazy things or whatever.	Father to Son				

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TABLE 2 (Continued)

Social worker 1			Social worker 2			Father			Son		
Outer dialogue	**Directed at**	**Inner dialogue**	**Outer dialogue**	**Directed at**	**Inner dialogue**	**Outer dialogue**	**Directed at**	**Inner dialogue**	**Outer dialogue**	**Directed to**	**Inner dialogue**
						In fact, in my experience, a chip off the old block, you also make those sharp comments.					
									The difference is between sometimes and always.	Son to Father	
I have to think a little bit about us	SW 1 to SW 2	I really was searching									
			Yes, for me it's why can we do that, because you are his father and you are his son, because you want to be seen by your father and feel that you are the most important to him.	SW to Father & Son	But there are other things going on here, yes, I can feel them in relation to my own father.						I thought it was so brave of SW 2 that he gave me a tap on my shoulder at the right time.
									Yes, because with friends I can be very sarcastic.		
		I was really happy with that.	And the moment that you have not felt that with your father at times, that comes so deep inside because you are his son. And that has been given a place somewhere I think and that's what it touches on.	SW 2 to Son				This is what I really liked about SW 2, this summary. **That rang a bell for me.**			SW 2 mentions the core of the problem here, **which I really liked**
									That is it.	Son to all	

Red, past; Green, present; Blue, future.
Italics, inner dialogue during primaire conversation.
Bold, inner dialogue during reflection in the reconstruction conversation.

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Outer dialogue

The outer dialogue is about how humor is used in the father-son relationship and how social worker 2 mentioned that the reason why jokes do not always come across well is that the relationship between a father and son is different from a relationship with a friend.

Inner dialogue

Social worker 2 felt that other things are going on during the conversation beyond just not understanding the humor between father and son. In the inner dialogue of social worker 2, it becomes clear that "*he can feel it in his relationship with his own father*". He then introduces this as a reflection after social worker 1 states to him that she is thinking of their relationship.

The father's inner dialogue shows that this shone a different light on the situation. In the inner dialogue, he states that "*he liked the summary of social worker 2* and *that rang a bell*" for him.

While social worker 2 was sharing his reflection with the father and the son, he tapped the son on the shoulder. Earlier in the conversation, the son had clearly said he did not want to be touched by his father. In the son's inner dialogue he shares that "*he found it so brave that Social Worker 2 tapped him on the shoulder at the right time* and *said that the core of the problem is expressed here*". It is the son who in the outer dialogue says: "*This is it*".

During the meeting, multiple inner voices and bodily expressions can be evoked. Social workers can actively use their inner voices and experiences and share these in dialogue with each other (Rober, 2005).

The interplay between the participants' inner and outer dialogues

The topic during this fragment concerned the relationship between the son and the father. The subject was about how they use humor in their relationship. It was unclear to them why they sometimes misunderstood each other while joking. The son states that he does not encounter the same misunderstandings with his friends.

Both social workers experienced that this was an important moment. Social worker 1 tried first with an explanation of what might have happened, which lead to a statement by the son that this was simply the way he is.

Then social worker 1 turned to social worker 2 and tried to engage with him, with their own relationship as a starting point. In her inner dialogue, she shared that she was searching for how best to continue. However, this opened up the opportunity for social worker 2 to share his reflections on the difference in relationships between fathers and sons and that the son wanted to be acknowledged by his father and know he is important to him. This emerged from his reflection on his relationship with his own father.

Being able to share this reflection with the father and the son, another voice was added to the conversation, which sheds a different light on the previous discussion on how well both are able to handle certain jokes. This lead in their inner dialogue to a reconstruction of the situation, which the son also makes clear in the outer dialogue. It helped to ease the discussion between the father and son. It had the same effect on the father, as he states in his inner dialogue that it rang a bell for him at that moment.

In this fragment, the social workers were able to find attunement between each other which led to an opening for social worker 2 to share his reflections. Thus another voice was added to the conversation which brought a new perspective to the situation (Rober et al., 2008). Adding a new perspective opened an opportunity to create a new meaning between father and son. This becomes clear in the inner dialogue and in the outer dialogue. It is apparent that the sharing of reflections gives meaning to the conversation and creates an opening for the dialogue to continue (Seikkula and Trimble, 2005; Seikkula and Arnkil, 2006).

In addition to what happens in the outer dialogue, a lot happened in the non-verbal communication between social worker 2 and the son. Earlier in the conversation, the son shared that he does not want to be touched. In this fragment, social worker 2 taps the son on the shoulder. In the son's inner dialogue, he saw this as a significant moment.

Discussion

In this case study, we found that sharing and withholding reflections can influence the inner and outer dialogues of the clients. This finding opens the door to more research on this topic for a broader view of the influence of sharing and withholding reflections and how social workers can find attunement in network meetings. Since it is the task of social workers to conduct more network meetings, we assume that if they are trained in this way of conducting the meetings they will feel more competent in this role.

In this case study, the network meeting was led by two social workers. We found that it was of benefit to the network meeting to have two social workers participate. While one social worker was more actively involved in the conversation, it allowed the other social worker to listen. In this way, he could let the conversation resonate in his inner dialogue and share this with the father and the son. Through the two fragments, we found out that it is important that the social workers also find attunement between each other. This observation could form an interesting premise for more research on how social workers attune to each other in the present moment.

We also want to point out how the method of stimulation recall could be useful in social work. For example, in the

fragment of sharing of reflections, it is worth mentioning that social worker 2 not only shared a reflection but also added a personal voice to the dialogue. Besides the personal voice, he tapped the shoulder of the son, while the son earlier shared that he did not want to be touched. This could be interpreted as crossing a boundary. Nevertheless, the son found it brave of social worker 2, which became clear during the stimulated recall. During the network meeting itself, the son stated this as the core of the problem by saying: *"This is it"*. Even though social worker 2 overstepped a boundary for proper professional conduct, he stepped into the dialogue-friendly social space.

It has been remarkable to have observed the reconstructed meaning by reviewing the network conversation with the clients. Using the method of video-stimulated recall brings up the question of whether and how this may be used more frequently after network meetings. The thoughts and feelings expressed in the recorded session belong to that of the present moment. Reviewing the recording from the previous day, and reflecting on the thoughts and feelings from that moment, led to new ideas and emotions at the present moment of watching the video. During that process, a new meaning was reconstructed, which enriched the relationship between the father and the son. For example, the son stated: *"I realised I have to deal with this, because my father will play a role in my life and social worker 1 will be gone from my life"*.

This happened while watching the video fragment where social worker 1 had asked social worker 2 to park the question in the video. Without the review, the son's inner dialogue would have remained unknown and there would have been no possibility to construct a new meaning. This raises the question of if social worker 1 had not asked social worker 2 to park the question, whether the son would have come to the same conclusion or not. Yet, only because of watching the video the next day, the son was able to make this statement.

More research is needed on how clients can benefit from this method and how this could be used in the process of conducting network conversations. And if this method is used, does it promote or undermine the basic principles of dialogism (Anderson, 2007; Anderson and Gehart, 2007), such as transparency and creating polyphony in network meetings?

This case study shows that the sharing and withholding of reflection by professionals in a network meeting has an influence on the inner and outer dialogues of all participants.

The sharing of reflections by the social workers led to clarity in the relationship between the father and the son. It showed the difference in comparison to the relationship with friends. In the inner dialogue between the father and the son, we see that this is a significant moment for them. It is the son who shares in the outer dialogue how the reflection resonates with him.

The outcome was that there was a better understanding between father and son, which strengthened their relationship and achieved attunement in the conversation.

In this study, we have seen the importance of sharing reflections in a network meeting, which contributes to giving an opening in the outer dialogue to share one's inner dialogue.

Data availability statement

The original contributions presented in the study are included in the article/Supplementary material, further inquiries can be directed to the corresponding author/s.

Ethics statement

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. Written informed consent to participate in this study was provided by the participants' legal guardian/next of kin. Written informed consent was obtained from the minor(s)' legal guardian/next of kin for the publication of any potentially identifiable images or data included in this article.

Author contributions

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

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"Always opening and never closing": How dialogical therapists understand and create reflective conversations in network meetings

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Tom Andersen's reflecting team process, which allowed families to witness and respond to the talk of professionals during therapy sessions, has been described as revolutionary in the field of family therapy. Reflecting teams are prominent in a number of family therapy approaches, more recently in narrative and dialogical therapies. This way of working is considered more a philosophy than a technique, and has been received positively by both therapists and service users. This paper describes how dialogical therapists conceptualise the reflective process, how they work to engage families in reflective dialogues and how this supports change. We conducted semi-structured, reflective interviews with 12 dialogical therapists with between 2 and 20years of experience. Interpretative Phenomenological analysis of transcribed interviews identified varying conceptualisations of the reflecting process and descriptions of therapist actions that support reflective talk among network members. We adopted a dialogical approach to interpretation of this data. In this sense, we did not aim to condense accounts into consensus but instead to describe variations and new ways of understanding dialogical reflecting team practices. Four themes were identified: Lived experience as expertise; Listening to the self and hearing others; Relational responsiveness and fostering connection; and Opening space for something new. We applied these themes to psychotherapy process literature both within family therapy literature and more broadly to understand more about how reflecting teams promote helpful and healing conversations in practice.

KEYWORDS

reflecting teams, dialogical therapy, family therapy, Open Dialogue, interpretative phenomenological analysis

Introduction

Family therapy brings together members of a person's social network, and takes a systemic view in the formulation of problems. Despite extensive evidence of the efficacy of various forms of family therapy (Carr, 2018a,b) less is known about how these therapies achieve positive change (Carr, 2010, 2016). The introduction of the reflecting team by Tom

Andersen (Andersen, 1987) has been described as revolutionary in the development of family therapy (Brownlee et al., 2009). Andersen was influenced by a social constructionist epistemology and the works of Gregory Bateson (Bateson et al., 1963) and Humberto Maturana (Maturana and Varela, 1980). These writings emphasised the construction of many unique realities based on perspectives and interactions with the environment. Maturana's 'multiverse' evoked many possible meanings, and many perceived worlds.

In his seminal paper outlining his approach, Andersen (1987) details the Milan model of family therapy, which included a reflecting team who would observe the interview with the family behind a one-way screen. The clinician interviewing the family would meet with the team, discuss the problems of the family, and the clinician would return with their formulation to the family. Andersen's experiment was to invite the reflecting team to trade places with the family, so that the family could listen to the conversation and reflections on what they had heard in the interview. Andersen and his colleagues felt that this would offer a more collaborative experience for families and allowed "direct access to the ideas of the team" (Biever and Gardner, 1995). The other effect that this had was to change the way clinicians spoke about the families, and how new information could be introduced to family members in such a way as to allow them to choose what aspects felt more relevant and important to them.

In Andersen's reflecting team approach, families were invited to construct their own meaning through listening to varying perspectives from members of the team. Conversations between team members were based on observations of the family, tentatively offered speculation on how family members may be relating to the problem, and inner sensations or images related to the problem. The aim of these conversations was to open up possibilities for the family, and allow them to decide what fit best with their experience. Importantly the stance of "both/and" rather than "either/or" allowed for a diversity of perspectives both between and within team members (Andersen, 1987). The delivery of multiple perspectives and responses to a problem is considered integral to this approach, allowing clients to witness "doubt and ambiguity" (Haley, 2002 pp. 31) within a team. Andersen argued that helpful conversations were those in which different versions or perspectives of the problem could lead to a shift in the family system.

The structure of reflective conversations in which the team of clinicians would talk to each other, but be heard by the family (within the same room, or on one side of the two-way screen), is unique to this approach (Bacigalupe, 2002). This shift in position for family members, from observed to observing, is intended to promote the co-construction of meaning in relation to the problem and potentially allow clients to take a reflective position on the discussion. Following team reflections, family members are invited to speak about aspects of the conversation that caught their attention, or what they had been thinking of during this time. Families are encouraged to choose the direction of further exploration or discussion of possible solutions to the problem (Andersen, 1987; Memmott, 1998; Pender and Stinchfield, 2012). Reflecting teams are widely used by family therapists internationally, and there is growing enthusiasm for the practice in both family therapy (Willott et al., 2012) and in supervision and training (Biever and Gardner, 1995; James et al., 1996; Castles, 2011). Reflecting team practices have been described with deaf clients (Munro et al., 2008); those with intellectual disabilities (Anslow, 2014); people with gambling problems (Garrido-Ferńandez et al., 2011); people with opiate addiction (Garrido-Fernández et al., 2017); those with eating disorders (Russell and Arthur, 2000); people in war-torn (Charlés, 2010) and residential settings (Faddis and Cobb, 2016) and with young children (Fredman et al., 2007). Reflecting team sessions have been found to increase family connectedness (Browne et al., 2020) and hope among family members (Egeli et al., 2014; Armstrong et al., 2018; Allan et al., 2019). Dialogical approaches such as Open Dialogue have taken up a modification of reflecting team practices as a core component of the therapy process (Sutela, 2012). The dialogical perspective inherent in the reflecting conversations aims to attend to the many voices present in a meeting and several landmark naturalistic studies have shown reduction in long term disability and service use in early psychosis (Seikkula et al., 2003, 2011; Aaltonen et al., 2011; Bergström et al., 2017). Open Dialogue was found to be superior to treatment as usual for recovery and reduction in disability for adolescents with severe mental health concerns (Bergström et al., 2022). Qualitative studies of dialogical approaches including reflecting teams indicate that family members and clinicians alike value these open conversations (Sidis et al., 2020) and find them helpful (Flåm, 2009; Garrido-Fernández et al., 2011; Pender and Stinchfield, 2014; Allan et al., 2019).

A few studies have used conversation analysis of dialogical therapy to describe the way in which therapists encourage hope and positivity between family members (Williams and Auburn, 2016) downgrade authority to emphasise knowledge of family members (Ong et al., 2020) and make inferences to reflect their close listening (Schriver et al., 2019). Reviews of the reflecting team literature have been conducted (Pender and Stinchfield, 2012; Willott et al., 2012; Harris and Crossley, 2021) each espousing the need for further process research to aid in understanding how the reflecting team process achieves the shifts described. Despite the obvious association with reflective capacity which appears to be linked to efficacy in psychotherapy (Ekeblad et al., 2016; Bourke and Grenyer, 2017; Cologon et al., 2017), no studies to date have focused on how dialogical therapists encourage reflective conversations between family members. The current study aims to illuminate the variety of ways in which dialogical therapists understand, describe and encourage reflective conversations among family members. It also explores what these practices achieve in relation to the experiences of practitioners and participants in reflecting team meetings.

Materials and methods

Procedure

Participants

Purposive sampling was undertaken by inviting members of an Australian dialogical therapy interest group (sent information *via* email) and an international social media dialogical practice interest group (information posted to the site encouraged participants to contact the lead author).

Twelve dialogical practitioners from a variety of academic backgrounds participated in the study. One participant identified as a service user and practitioner. Eight participants were Australian, with two from Europe and two from the United States. Eight of the 12 participants identified as male and four as female with ages ranging from 30 to over 60 years. Participants practiced in various work contexts including community, outpatient, inpatient, and private practice. Experience in the Open Dialogue approach ranged from 2 to 5 years to greater than 20 years. See Table 1. Study methods were reviewed and approved by the local Human Research Ethics Committee (2021/064) prior to study commencement.

Interviews

Twelve mental health professionals took part in semi-structured in-depth interviews. All interviews were conducted using zoom video conferencing software and were 90 min in duration. The first author who is a clinical psychologist conducted all interviews. Interview questions were developed *a priori* by the research team and included questions such as, "How do you think reflective talk emerges in your work with families?" and "What actions have you taken to support reflective processes or reflective talk among family members?" Although the interview focussed on the participants' experience of reflecting teams and on how these therapists conceptualise and encourage reflecting talk among family members participants were encouraged to speak freely on aspects of practice that were relevant or important. Interviewees were asked to describe practice experiences alongside theoretical understandings of reflective processes in network meetings. Interviews were conducted from a social constructionist and dialogical perspective, in which the interview is understood as a setting for social discourse and the production of personal narratives (Tanggaard, 2009; Kvale and Brinkmann, 2015). In line with the critique of qualitative interview research described by Bøe and colleagues, a particular intention during the interviews was to attend to differences between participants, expressions of uncertainty and the variety (Bøe et al., 2021) of actions therapists may engage in as part of their therapy work.

TABLE 1 Study participants.

Participant	Years of Open Dialogue experience	Workplace context	Discipline
P1	2–5	Community	Psychology
P2	2–5	Community	Nursing
P3	>20	Outpatient and private practice	Psychiatry
P4	2–5	Community	Social work
P5	2–5	Community and private practice	Psychology
P6	2–5	Community	Psychiatry
P7	11–15	Community	Psychiatry
P8	6–10	Inpatient	Nursing
P9	6–10	Private practice	Psychology
P10	6–10	Community	Psychology
P11	2–5	Community	Nursing
P12	16–20	Community	Family Therapy

Analysis

Transcripts were recorded and transcription was conducted by the first author. Given the intention of this study was to attend to both ideographic and across group patterns, an Interpretative Phenomenological methodology (Allan and Eatough, 2016; Smith, 2017, 2018) was applied to the recorded transcripts. The analysis was informed by Bakhtin's dialogism (Bakhtin and Emerson, 1984) that recognises that meaning is created between participants and that each utterance is inherently polyphonic. We also considered the *qualitative fallacy* described by Bøe et al. (2021) in our analysis and attended to complexity and contradictions in the data and to participant uncertainty and hesitation evident in transcripts. The analysis included initial immersion in the data, with the first author conducting the interviews, reviewing transcripts and several close readings of all transcripts in full. Notes and annotations were made in the text, from which further reflections on divergent themes, along with individual participant's experiences, were considered. As described by Smith and Shinebourne (2012), the hermeneutic circle method was used to relate participant's experiences to broader themes using an explorative reflexive approach (Binder et al., 2012). Through an iterative process, themes were produced, however variation and contradictions to emerging themes were also considered. A dialogical approach to interpretation (Wells et al., 2020) was undertaken in which members of the research team with experience in various psychotherapy approaches and in linguistic discourse analysis met to interrogate these emerging connections from diverse perspectives. Finally, themes alongside idiographic conceptualisations and understandings of reflective processes were refined.

Results

Participants' descriptions and conceptualisations of the reflecting team process contained multiple perspectives on therapist actions and on the understanding of what reflecting teams achieve in the therapy context. While descriptions centred

on the reflecting team process, many aspects were linked with general dialogical therapeutic principles. In line with the aims of this study, the focus of analysis stayed close to experiences in clinical practice or in Open Dialogue training and supervision.

Four interrelated themes were identified to capture both the way in which participants conceptualise reflective conversations in these family and social network meetings, and how these conversations are created:

1. Lived experience as expertise.
2. Listening to the self and hearing others.
3. Relational responsiveness and fostering connection.
4. Opening space for something new.

Lived experience as expertise

Participants describing their practice and conceptualisation of reflecting teams spoke about a shift in how expertise and knowledge are held in reflecting team conversations. They described a genuine curiosity and positioned themselves as co-creators of the therapy talk. This invited family members to relinquish more traditional expectations regarding expertise. Contrasting with the expectation that service users may hold of mental health professionals, participant 9 describes not just a shifting of the notion of who is expert but also that expertise is not a requirement for problem resolution.

> I think that, yeah, it empowers them and it helps them maybe renegotiate this notion of the expert. they say that yeah, what brings us here is that we wanted to hear the opinions of the experts. And just by talking on a more personal level, like sharing emotions or sharing your understanding, I think it makes it…it helps them understand that they are the experts and or that there is nothing to be expert about.

This requires not only a genuine intereste in the lived experience of family members but also a levelling of authority. Participant 11 noticed a shift in both expertise and power:

> So, you know, that's a sort of, but the idea that it takes, that it critiques that expert… expert position and is saying 'Well, we're kind of one of you too, we're having these inner thoughts and our doubts. And so it is a kind of democratizing of… of this gathering, this group – of trying to work out what's happening, and how can we, you know, or make a difference

In the statement above the participant links the challenging of the expert position to a collaborative effort to understand and learn about each other. This privileging of lived experience over positional expertise allows for dialogue without rank (Bakhtin and Emerson, 1984). They also include the sharing of inner thoughts and doubts, promoting the democratising of the space. The imagined group meeting in which all members hold power and agency to "make a difference" is joined together in their choice of the pronoun "we."

Similarly, participant 1 describes both the elevating of lived experience and the tentativeness of their professional voice in the reflecting team process:

> I think you give epistemic authority to the client, and the family, like the knowledge. So you ask things in a way that values their perspective rather than yours. And then similarly, when you offer yours, it's like what… what has been recommended, it's done in that way that is tentative… and that seeks feedback. is never stated as factual interpretation of their experience… is always offered as something that can be disagreed with.

Here the practitioner's actions are linked with valuing the lived experience of family members along with an invitation to be an agent in the direction of therapy talk, or what is spoken about, and who can speak. Valuing each family member's perspective and the expertise that they hold by virtue of lived experience invites an equal position and an opportunity to join as an active participant. This invitation to participate holds within it an openness to a different perspective, to attend to the talk on your own terms. Another practitioner (P2) speaks about how they describe the reflecting team process to family members:

> We're going to turn to each other and… and look at each other and have this… reflect this in this way. To give you an opportunity to just listen to us without feeling like you're under the gun and you have to respond. And then after we do it, we're going to turn back to you and you get the last word.

Here an emphasis on reflecting team members speaking to each other, and family members being allowed to listen without perhaps the usual expectation to agree with clinicians in the meeting, conveys an epistemological shift. This process of team members speaking in front of the family but to each other can be likened to sitting in the back seat, rather than being a driver of a vehicle, where the participant is able to view the problem without having to respond to the discussion. Not being expected to respond either verbally nor in non-verbal expression as per social convention provides an opportunity to family members to hear and consider the problem and what is being said. Family members' being handed the "last word" once again privileges their expertise and agency in the conversation.

Listening to the self and hearing others

Dialogical therapy practitioners in this study also spoke about their own inner dialogues, attending to internal thoughts, sensations, emotions and images. This kind of listening was constructed as noticing one's own inner self in a way that supported them to hear others and respond to them. Participant

10 describes this noticing of others as synchronised with noticing oneself:

> I think for me, it's about having, like, genuine, like really authentic curiosity…like, my attention is drawn to this and it's almost like it's saying something to me, and I want to know more about it. Um, and so, so that's what's coming up for me in that process.

In this description of practice, curiosity is applied to both the family members' verbal and bodily expressions as well as to the inner experience of the practitioner. Here, the practitioner uses their noticing of the self as a pathway to listening to the experience of others. The practitioner's own internal experiences become eyes and ears. This movement from inner to outer worlds guides the actions in the meeting. Participant five speaks about the way in which this connection to self encourages this listening:

> To connect with myself and to think right—How is my body? How is my mind? Am I present? Am I listening? What do I want to know more about? Why? What do I want to ask about that's been said? Yeah. To be. Yeah, to be oriented to my own experience.

Orienting to the way in which the act of attending to others ripples through our own inner experience seems akin to mindfulness and potentially opens the practitioner up to new understandings. Practitioners in this study considered this self-awareness as essential to being responsive to the needs of family members. Participant 9 reflects on this:

> Yeah, I think that's the… It's the freedom to share, but it's also the attentiveness to oneself, that is, like a prerequisite to be of best support to people, we talk about how we are in their presence or what they evoke in us

This self-awareness was also described by a number of practitioners who experienced reflecting teams during training and supervision. Being in the listening position during reflecting team talk also appeared to invite a similar connection between attending to the self while hearing others. Participant 9 describes the experience of being reflected on:

> That you can understand yourself, be aware of yourself in some way because somebody has noticed something about you and then as you speak about it, you can you can hear yourself, see yourself as well as others getting to know you.

This noticing described above may relate to present moment changes in voice tone, or non-verbal expressions such that the person being reflected on may choose to connect what is spoken about to their own experience. One practitioner (P8) uses the auditory metaphor of an echo to describe their experience of being reflected on during reflecting team training:

> When you think about a mirror, it's more like a one to one thing, but an echo doesn't sound like the real thing, but you can still make out what was said. So I think I heard… I heard myself through the other person.

To hear one's own words and experiences spoken about by reflectors in this way offers an opportunity to experience this through the lens of another person's life experiences and present moment responses. This implies a relational reflexivity (Burnham, 2018) in the way in which attending to both the self and others simultaneously provokes a deeper understanding for both reflectors and those experiencing a reflecting team.

Relational responsiveness and fostering connection

Many of the participants in this study spoke about the way in which the reflecting team process engendered a sense of "being with" families (Shotter, 2005) and characterised this connection as essential to the process. This was created in a variety of ways including attending to emotional and bodily responses and staying present. Participant 9 described this:

> I think you manage to connect in a way and through connection comes healing. And I think, I mean, through this more… making use of myself, in the sense of the emotions, and not so much the thoughts, I think, yeah, it allows them to…to be together at a more personal level.

Here healing and recovery is understood as a result of being together in a way that is described as personal. This is conveyed as a result of connecting to inner experiences. Other practitioners understood this connection in terms of physiological attunement (P6):

> Our responses, you know, physiological responding to each other. Synchronization, that… you know, is actually that happening at a physiological level so that there is this kind of... 'I'm connecting with what you're feeling', and... and so, what they're feeling actually gets somewhat amplified and noticeable and more comfortable.

A physiological attunement is understood here as allowing emotional responses to be seen (amplified) and acknowledged. This is described in the above as a connection with what others are feeling, which allows for both noticing and comforting others in the presence of difficult emotions. This acknowledgement of experience is associated with insight by another practitioner (P8):

> And I think, at least to begin with, and therapeutic settings, it, the acknowledgement sits at the core of what caring is about. And I think that the acknowledgement is what allows other things to happen in terms of insight, but one thing is that the

> original speaker is.is sending out a signal. A noise. And then, for me, the first job of the clinician is to say that there's someone out here and you are being received.

The prioritisation of relationally responding is clearly articulated as the "first job," and is portrayed as allowing for insight in reflecting team conversations. The acknowledgement of the family member's experience is centred in the practice as what allows things to happen. The study participant's choice to describe themselves as "someone out here" evokes a connection that assures the family member that they are not alone. This connection was also linked to staying present. Participant 4 describes their practice of present moment attending and responding to family members in a network meeting:

> In this moment, you know, that I might think of all the things that you're going to ask me. But really, all I can do is respond to the things that you're saying to me right here right now. And that feels like a much more genuine thing to be doing, sticking to the present. As much as you want to talk about that thing that you didn't quite resolve in the last time you were all sitting together, actually this is a whole new piece of music.

The engagement of the auditory metaphor of music in this description not only serves to emphasise the changing nature of moment-to-moment interactions but also a sense of appreciation for the experience of being a listener in this context.

Opening space for something new

This introduction of different voices, perspectives, and understandings in reflecting team talk has been described by Tom Andersen (Andersen, 1987) and others (Anderson and Jensen, 2007; Pender and Stinchfield, 2012; Shotter, 2015). Participants in this study described the moments that allow new information to emerge in network meetings. Participant 4 describes this curiosity and uncertainty as opening space for thinking differently:

> You know, we use words around the space, always opening and never closing anything. It's recognizing the... the importance of... of things that are spoken together...what has been fed back to me is this idea, particularly from parents, of feeling like they've, they've really been heard, and that their experience has been felt, or that words have been shared about their experience that are different, that are making them think differently about what they had shared.

This participant makes a connection between feeling heard and thinking "differently" about their experience. The description of "always opening" can be understood as the practice of seeking to understand more, or to understand various perspectives and ways to experience the words being spoken. This is placed in opposition to "closing" which invokes a definitive, single truth. Similarly participant three discusses their perceptions on what closes conversations and what opens space for new things to emerge:

> As reflecting team members we are discussing about our feelings, bodily sensations and nonverbal things that are in the room. When we are thinking about what kind of heaviness or pain or something there might be, um, well, to me, I feel it's opening space for something to come. Of course, sometimes, quite often people also talk about this metaphor of illness, that's so common. That's closing doors from understanding, when families start thinking about this illness in their kids, that is closing doors of wondering about what's going on.

The description above captures the uncertainty described in dialogical practice (Seikkula and Olson, 2003), which here is linked to wondering and learning more about an experiences. This is contrasted with the "closing doors" of certainty related to medicalisation of distress and mental experience. Another participant (P6) also reflected on this uncertainty in reflecting team conversations as not-knowing (Anderson and Goolishian, 1992) and the way in which this allows new ways of thinking about things to emerge:

> Whereas if you missed the mark, in this loose kind of, you know, this kind of creates a position, I think, where the person can have that internal conversation with themselves again, and so they go, I don't think that's quite right. I think it is this, you know, you've got it wrong. But suddenly there is you know, something's happening, the way it's understood that can be brought in to the dialogue with the network too that can become new information or new understandings.

Here therapy participants are invited to disagree, and disagreement is represented as allowing for more information to be shared and different perspectives to be acknowledged. This process not only describes the co-development of new ideas but also the recognition that family (and reflecting team) members may learn things about each other that were previously unspoken.

Discussion

Dialogical therapists participating in this study described a variety of practices and understandings in their psychotherapy work. The aim of this study was to understand more about how practitioners conceptualise reflective conversations and about what actions they take to encourage them. Our secondary aim was to make sense of the positive responses to reflecting team practice from both practitioners and family members (Naden et al., 2002; Fishel et al., 2010; Willott et al., 2012; Egeli et al., 2014; Sidis et al., 2020; Harris and Crossley, 2021) and reports of improved outcomes compared to standard treatments for both reflecting teams (Brownlee et al., 2009; Garrido-Ferńandez et al., 2011;

Garrido-Fernández et al., 2017; Armstrong et al., 2018) and Open Dialogue (Seikkula et al., 2006, 2011; Gromer, 2012; Bergström et al., 2018, 2022). We explored transcripts from in-depth interviews with dialogical therapists using Interpretative Phenomenological Analysis (IPA). This method was chosen as a means to illuminate divergence as well as convergence in the data. We also embraced dialogical perspectives in considering pauses and hesitations during the interviews. Our findings link to theoretical and practice based understandings of dialogical therapy (Ong and Buus, 2021) and also provide detailed, nuanced perspectives of reflecting team practice and what this practice may achieve.

Our first theme, Lived Experience as Expertise, aimed to capture practitioners' approach to both knowledge and power in the therapy setting. Laitila (2009) differentiated between horizontal and vertical expertise in family therapy by considering the intersection between the accumulated knowledge of an individual, including their lived experience (vertical) and the co-constructed knowledge achieved by utilising the resources of all present in a session (horizontal). Practitioners in this study described a respectful inquiry into the lives and experiences of family members along with tentative offerings of their own present moment experiences in response to hearing them. These actions were often noted to be in contrast to mainstream therapy practices in which therapists are often positioned as expert knowledge holders. Efforts to dismantle positional power in mental health settings are becoming more prominent among mental health consumer groups (Gee et al., 2015; Holmes and Papps, 2018) and alternative approaches which directly consider the operations of forms of power have been recently developed (Johnstone and Boyle, 2018). These efforts recognise a harm described as epistemic injustice (Leblanc and Kinsella, 2016; Carver et al., 2017; Crichton et al., 2017; Naldemirci et al., 2021), caused by mental health professionals who may medicalise distress and inadvertently silence knowledge that arises from lived experience of that distress. One participant described reflective practices as democratizing the clinical setting. This is achieved through an authentic recognition of the value of knowledge gained through personal experience of the problem.

Anderson's descriptions of Collaborative therapy, which has been influenced by Andersen's reflecting team ideas and in turn influenced dialogical approaches, includes two important ideas related to this theme. Anderson's collaborative therapy was based on the understanding of therapy interactions as meaning-making linguistic systems. This approach encourages clinicians to embrace genuine curiosity and to ask questions from a position of "not-knowing" rather than from a model or method that seeks specific answers (Anderson and Goolishian, 1992). In this way therapy participants can be invited to make sense of their experience in a way that does not privilege one person's voice over another's. This theme also connects to Bakhtin's conceptualisation of "expressing authentic human life" which could only be achieved in dialogue without rank (Bakhtin and Emerson, 1984). Bakhtin understood dialogical conversations as those in which one participant's utterance was presented as a response in some way to another participant. This he contrasted with monological conversations in which one participant speaks with little consideration of the experiences of the other or from a single perspective. But Bakhtin also stressed that utterances are, in a deeper sense, always "dialogic" in that "to speak or write is always to reveal the influence of, refer to, or to take up in some way, what has been said/written before, and simultaneously to anticipate the responses of actual, potential or imagined readers/listeners" (White, 2003).

There are of course some important caveats to treating reflective practice as a heteroglossic and democratising force. Firstly, the democratisation can only be partial as there are professional and legal responsibilities always in the background as potential meanings or actions that may need to brought to the fore. Critiques of the way that discourse has been "democratised" and "conversationalised" across professional and bureaucratic spheres such as medicine, law, and education caution that sometimes all these changes mean is that the power goes "underground" (e.g., Fairclough, 1992; Maley et al., 2013). Based on therapists' responses in this interview study, we do not see reflective practice within therapy as an example of the kind of subterranean control that has been documented elsewhere. Secondly, as well as democratising relations between therapists and clients, reflective practice is also likely, at least within the therapy session, to affect hierarchical relations between family members—between the parents in a family; between parents and offspring; between siblings of different ages, genders, abilities, and interests, etc. Although this point was not explicitly made by interview participants, it is an important one to follow up in future research. The expanded dialogism of reflective practice, in which even the professional's views are routinely questioned, could create positive "wiggle room" (Erickson, 2001) for new capacity and authority to speak within a family. Of course, this may not be without unsettling effects.

The second theme from this analysis listening to the Self and Hearing Others, describes practitioners' attending to their own inner dialogues and experiences during the therapy talk. This is understood as important in order to respond to others in the meeting in such a way that they might feel heard. This adoption of therapist reflexivity during therapy conversations is not unique to reflecting teams (Brown et al., 2016; Bourke and Grenyer, 2017; Cologon et al., 2017), however, in using the reflecting team process, dialogical therapists share these inner experiences with clients in a way they hope might be helpful to them. Dialogical therapists participating in this study understood their own responses to therapy talk to be essential to guiding the conversation, and to the process of reflecting team practice. These two activities of noticing the self and noticing others appear to occur simultaneously and be mutually influential. Burnham described this *relational reflexivity* in which people are invited to be curious about the inner experiences of others as a means by which therapeutic relationships might develop and helpful conversations can occur (Burnham, 2018). Similarly, narrative

therapist Johnella Bird used the term *relational consciousness* in her work (Bird, 2004). For her, noticing responses and experiences relationally, denotes a shift away from a judgmental stance towards an acknowledgement of the relational environment we live in. For all participants in therapy conversations, this may lead to connecting to un-tapped resources. These practices can also be linked to the concept of the relational mind (Bateson, 1972) in which the mind is understood as a system in constant interaction with the world and with other minds. Since Bateson and related authors inform many therapeutic approaches, it is interesting to ask what is distinctive about having therapists give voice to their own experiences and hear each other speak about those experiences in the therapy session itself, along with clients. And how might this particular mode of talk foster a specific kind of relating that works for family therapy?

As a partial answer to these questions, we suggest that attending to one's own inner dialogues and experiences as a practitioner may also be understood as an orientation to self-experience in relation to others. There was a close link in practitioners' descriptions between the expressions of family members and what practitioners shared during reflecting team conversations. How dialogical therapists come to decide what should be shared in reflecting team conversations may be associated with what Shotter describes as *action guiding anticipations and understandings* (Shotter, 2015). Taking up the work of Bakhtin, Shotter suggests that as we learn to be in dialogue, we construct our utterances in anticipation of a response from others. In order to do this we must be attuned to others and express these utterances in ways that reflect a sense that we are with them. Reflective practice reimagines who these others are, and thus how we attune to them.

This prioritisation of attunement is also present in our third theme Relational Responsiveness and Fostering Connection. Participants in this study described engaging a deliberate focus on embodied attunement as part of their practice. This attunement was understood as supporting practitioners in their attempts to be responsive to the needs and experiences of family members and to the development of trust and alignment. This experience of shared and co-created meaning is associated with healing and trust (Seikkula and Trimble, 2005). The practices described by therapists in this study include not only shared meaning, but also a sense of appreciating and attending to other's experiences. Anderson (2012) describes *relationally responsive practice* as a way of being and philosophical stance. Taking up Derrida's notion of hospitality (Larner, 1994) she emphasises the importance of acknowledging that we are both guest and host in the lives of families who seek support. This she describes as "being courteous, sensitive to their uneasiness, and careful" (p.16) but also to view the stories clients present as a *gift*, of fragments that unfold as client and therapist reflect together. The musical metaphor employed by one participant suggests that any given session would be considered to have new form, harmony and expressions of emotion than a prior piece of music (therapeutic interaction) which may have been very different across all these dimensions/aspects.

Our final theme—Opening Space for Something New—links closely to dialogical practice and the associated concepts of uncertainty and polyphony. Study participants' descriptions of *opening* conversations also described a therapist position of not-knowing, which allow for a conversation considering possible options to emerge. Tolerance of uncertainty, considered a key element of Open Dialogue (Olson et al., 2014) relates to not rushing to make decisions about treatment too early in the process of a meeting. These decisions are made collaboratively and carefully considered in the context of the family's current situation. Dialogical therapists in this study did not see themselves as holding more knowledge than the family members and instead described a focus on relational knowledge that is constructed in the dialogue. Embracing uncertainty about where the conversation is going, or how to best respond to the family, appeared to support unexpected and yet relevant stories and resources to emerge.

Bakhtin used the musical metaphor *polyphony* to describe dialogical interactions as inclusive of independent and equally important voices (Bakhtin and Emerson, 1984). Dialogical practitioners do not attempt to produce consensus or a single agreed truth but are instead interested in varying perspectives on problems. This applies not only to hearing from each person in the meeting, but also in attending to different voices within individuals. Our participants described being open to "wondering" about these perspectives, which appeared to create new ideas. During reflecting team conversations, practitioners also described being able to share opposing views about what they heard, so that family members get a sense of multiple perspectives on a problem between people, and perhaps even within a person. This practice perhaps permits family members to disagree with each other and with therapists and to open up new ways of thinking about the problem.

The reflecting team process described by Tom Andersen has been widely adopted and adapted and remains an unusual innovation in psychotherapy. Drawing on ideas from social constructionism, Maturana's multiverse and dialogical philosophy the practices of reflecting teams privilege multi-voiced perspectives, lived experience and embodied responsiveness more than a model or technique. Practitioners participating in this study conceptualised these aspects of practice as key to recovery and healing. Engaging in this way may encourage both mental health professionals and service users to connect with present moment inner experiences as they occur in the context of meeting with others.

Although evaluative research into Open Dialogue is still in its infancy, a number of longitudinal naturalistic studies have shown better outcomes for young people with psychosis who have participated in this approach (Seikkula et al., 2006; Bergström et al., 2017, 2018) compared to those provided standard treatments. Family Psychoeducation for early psychosis also appears to be one of the few psychological interventions shown to reduce relapse rates (Leff et al., 1990; Leff, 2000;

Harvey and O'Hanlon, 2013; McFarlane, 2016). Perhaps some of this can be attributed to simply involving the network in the treatment. Little is known about process factors in family therapies for psychosis (Grácio et al., 2016) although family cohesion is suggested to moderate general levels of distress in family members and young people (Brown and Weisman de Mamani, 2018). Other process studies in family based interventions for psychosis have emphasised therapists' listening to participants' experience, a needs focussed approach and developing a collaborative alliance (Grácio et al., 2016), all of which would seem likely to be enhanced by reflective practice given our findings above especially around the theme of listening to self and hearing others. Studies inquiring about family member's experiences with family based approaches for psychosis indicate the importance of being responsive to the particular concerns of the participants (Sundquist, 1999) and attending to participants stories to understand the experience of psychosis (Buksti et al., 2006). Therapist responsiveness in dialogical therapy for psychosis has also been associated with shifts in client's agency and a co-construction of words, meanings, and consequent emotional responses (Avdi et al., 2015), which also resonates with how practitioners in our study described reflective practice as a way of inviting client agency.

The themes identified in this study appear to relate to practices which may be considered common factors in helpful therapies (Wampold, 2015) and shift the conceptualisation of psychotherapies from medical discourses to conversations that promote healing (Wampold, 2001). These healing practices have been described as an emotionally confiding relationship with the healer, a healing context or ritual and a way of understanding or making meaning of distress (Frank and Frank, 1991). Reflective teams may also support network members to enter into personal reflections about themselves and others, a practice which has been described from an individualist perspective as mentalisation (Fonagy and Target, 2006) or metacognition in the literature on psychosis and severe mental illness (Lysaker and Dimaggio, 2014; Dimaggio and Lysaker, 2015). Increasing reflective capacity is proposed as a common aim across various forms of psychotherapy (Goodman et al., 2016) and therapists who show greater capacity for reflection tend to produce better outcomes for their clients (Bourke and Grenyer, 2017; Katznelson et al., 2019). This study may provide some insight into the outcomes observed for psychosis.

Finally, we note that the practitioners participating in this study relayed practice descriptions that were closely linked to the theory and literature relating to dialogical therapies. As a needs adapted approach, the content of network meetings may vary significantly across families, and even between meetings. This has added complexity to the measurement of fidelity to the Open Dialogue approach (Waters et al., 2021). Insights from the current study provide a greater understanding of the *approaches* some practitioners use in reflecting teams and dialogical therapy more broadly. Perhaps interviewing practitioners about their practice may be another way of ascertaining fidelity to an approach such as this one.

Study limitations

This study explored the practices of dialogical practitioners with a specific focus on reflecting teams. Our in-depth interviews with 12 dialogical therapists are not representative of the international community of practice that exists today but aimed to provide insights into reflective teams in practice. These interviews are also not representative of all dialogical reflecting team practices or experiences with this approach. We acknowledge we focussed here on a particular outcome of the practice, that is, reflective conversations, and how these are generated. This may have skewed our participants' descriptions of the practice and we may have missed negative or unhelpful experiences. Care was taken to make the interview prompts relatively neutral in order to avoid positive or negatively valanced responses. As indicated by the results, participants' did not provide any descriptions of negative or unhelpful experiences. This may in part be due to their affiliation and commitment to a therapeutic approach that has reflective processes at its core. Future research might also include interview prompts that more explicitly ask about negative experiences. We also note that the lead author on this paper has trained in and provided Open Dialogue for 6 years, which is likely to be influential in the analysis. Other authors on this project who contributed to the dialogical analysis include two clinical psychologists with expertise in cognitive therapies, parent based interventions and attachment based approaches and an academic with experience in using linguistic analysis the study of psychotherapeutic and other clinical discourse. Further broadening of this analysis to include other relevant voices may have added to our findings. While our analysis and discussion has opened potential avenues for considering how these practices support recovery, further research is required to fully understand how these practices promote change. A particularly welcome next step would be to explore the authentic talk that constitutes reflective practice *via* recording therapy sessions, and to compare how reflective practice is conceptualised in theory, as discussed in the present paper, with what practitioners and clients actually do and say in therapy.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving human participants were reviewed and approved by University of Wollongong Human Research Ethics Committee. The patients/participants provided their written informed consent to participate in this study.

Author contributions

AS was responsible for conducting all interviews, data analysis, and manuscript preparation. AM, JP, and FD contributed to data analysis and provided extensive comments on the manuscript in preparation for submission. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Co-therapy in Open Dialogue: Transforming therapists' self in a shared space

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The present study aimed to explore co-therapists' relationship and how therapists' individual presence influences this relationship in Open Dialogue. Although co-therapy is key in Open Dialogue network meetings, the processes of that relationship remain largely understudied. The study applied thematic analysis to semi-structured interviews with 20 Open Dialogue trained therapists working in public and private sectors internationally. The results indicate that therapists are present in a meeting with their experiencing and professional self. Specific co-therapy processes allow co-therapists to attune to one another verbally and physically, creating a shared space that promotes new common understandings, shared responsibility and ultimately a transformation of each therapist's self and practice. Trust between co-therapists seems to be a prerequisite for co-therapy to flourish. Results of the present study reveal a dynamic influence of co-therapy practice, in which co-therapy promotes a more dialogical personality and allows the therapists' own transformation, which in turn enables common understandings and sharing of responsibility. Considering the growing interest in dialogical approaches and Open Dialogue trainings, trainers, supervisors, and practitioners need to be aware of and attend to the dynamics of co-therapy relationship in order to care for themselves, their team and ultimately the networks they collaborate with.

KEYWORDS

Open Dialogue, co-therapy, professional self, experiencing self, self-transformation, dialogic practice

Introduction

Open Dialogue is a philosophical and therapeutic approach of being with people in times of crisis/need, as well as a way of organizing mental health services based on network meetings (Olson et al., 2014; Putman, 2022b). Network meetings involve a team of at least two professionals, the person of concern and his/her social network, namely relatives, friends, colleagues or other service members already engaged in the individual's care (Putman, 2022b). In Open Dialogue meetings practitioners of different professional backgrounds come together to form inter-agency groups as a way to promote polyphony (Seikkula et al., 2001; Olson and Seikkula, 2003). Professionals' teams often include, among others, psychiatrists, psychologists, occupational therapists, psychiatric nurses, social workers and experts by experience, known as peer workers (Nelson et al., 2022; Razzaque et al., 2022). For the purposes of the present study, all professionals involved in network meetings will be referred to as "therapists." Different professional backgrounds, with diverse ways of meaning making, may influence therapists' reflections with their co-therapist and their dialogue with the network (Holmesland et al., 2014).

Co-therapy, meaning two or more therapists working together in sessions with clients or families, has been developed in the field of family therapy in clinical and supervision settings and is in the heart of Open Dialogue practice (Ast et al., 2019). Although it is acknowledged that the quality of co-therapists' relationship influences treatment (Borchers et al., 2013), the prospects and challenges involved in co-therapists' relationship remain largely understudied in the field of Open Dialogue literature. As every relationship is unique, when collaborating with different co-therapists, practitioners might share different aspects of themselves and thereby allow diverse opportunities for the network members to explore. In appreciating the importance of each therapist presence and use of self in therapy, it is worth exploring how co-therapists experience their relationship, and how they attend to their self while promoting continuity of care with the networks. The present study aims to contribute to the limited dialogue around co-therapists' relationships and the processes involved, expanding, thus, on the literature of co-therapy in the Marriage and Family therapy field and the Open Dialogue approach.

Co-therapy has been widely practiced in Marriage and Family therapy, enriching the professional role of the therapists, as it can offer more resources, alternative perspectives and hypotheses (Hannum, 1980; Hendrix et al., 2001; Reed, 2013). Through the ways co-therapists collaborate and talk to each other, they can act as a role model for couples and families for alternative ways of communication patterns (Hannum, 1980; Hendrix et al., 2001). Co-therapists complement each other through alternating roles, from active to reflective positions, support each other to maintain a neutral stance and avoid being absorbed by the family dynamics, qualities that were believed to be helpful in systemic practice (Selvini et al., 1980; Benjamin and Benjamin, 1994).

In ensuring these qualities, training and supervision practices have been recognized as key to allow the space for therapists' professional development following the co-therapy relationship (Hendrix et al., 2001). A non-competitive and united team is likely to contribute to the growth of both clients and therapists (Selvini et al., 1980). To achieve this, it is important that each therapist acts as a host to both the clients and their co-therapist, making each therapist a host and guest at the same time. Considering therapists as both hosts and guests in a meeting is in line with suggestions that having two therapists allows for the clients' greater sense of continuity and permanence, while also preventing therapists' burnout (Hoffman et al., 1995). It also points to the importance of exploring the relationship between therapists, as well as the supervision and/or in session practices that allow this hosting experience to be cultivated.

Even though co-therapy has been recognized as an effective and often constructive practice in the Marriage and Family therapy literature, it has also received some criticism. Besides practical challenges in terms of time demands and increased cost, challenges regarding use of co-therapy might arise when co-therapists have control issues with each other, an erotic relationship, and when clients are trapped in co-therapists' symbolic therapeutic parenting (Russell, 1980; Bowers and Gauron, 1981; Haley, 1987; Hendrix et al., 2001). These concerns are highly valuable and point to the importance of co-therapists being both self-aware but also attentive and caring of the relationship with each other, to assist the network of concern. Trainees collaborating with different co-therapist dyads commented that they found challenging the possibility that, when working with a co-therapist, there is an increased likelihood to learn something new about themselves (Hendrix et al., 2001). Although the authors did not further discuss this, it is possible that, when collaborating with co-therapists with different levels of experience, issues around control and hierarchy might arise, increasing levels of complexity and the possibility of unexpected issues emerging in a meeting. From a dialogic point of view this might be perceived as an opportunity rather than a challenge, as therapists' self-attentiveness and being aware of their emotional reactions in therapy can offer valuable insights to the network and the process of therapy (Rober, 1999).

In dialogical practices, co-therapy builds on therapists' non expert position and focuses on more relational characteristics in a network meeting, as a means to encourage dialogue (Seikkula et al., 2012; Hornova, 2020). Dialogue is understood as a joint process that develops within network meetings through promoting a language that opens new flows of questions and new discourses (Seikkula, 1995). Co-therapy is inspired by and inspires in turn the seven core principles of Open Dialogue, both in how services are organized – assisting in immediate help, inviting the social network, having flexibility and mobility, maintaining responsibility and psychological continuity – and in the way of being with people – tolerating uncertainty and dialogism (Olson and Seikkula, 2003). "Two or more therapists in a team meeting" is the first of the twelve fidelity elements to dialogic practice (Olson et al., 2014). Having multiple therapists in a team meeting with a network supports the development of polyphony, through promoting alternatives and giving space to different voices (Valtanen, 2019; Hornova, 2020). Open Dialogue practitioners perceive dialogical co-therapy as a process that entails unique relational qualities, including the ability to disagree with each other, willingness to be challenged in therapy, taking care of the co-therapists' relational space, and finally being aware of and talking about embodied responses (Hornova, 2020).

During Open Dialogue meetings, therapists tend to respond to networks' experiences on an embodied and verbal level (Shotter, 2011; Cromby, 2012; Borchers et al., 2013; Kykyri et al., 2017; Seikkula et al., 2018). When therapists share their feelings, using their affective responses and their embodied experiences, their co-therapist is likely to do the same and 'contaminate' this way of talking to the whole network (Borchers et al., 2013; Hornova, 2020). In this way, dialogical co-therapy allows greater body-awareness and self-reflexivity (Hornova, 2020). Growing research in the 'Relational Mind in Events of Change in Multi-actors Therapeutic Dialogues' reveals an embodied synchrony in the physiological responses of members of the network and the therapists (Karvonen et al., 2016; Päivinen et al., 2016; Kykyri et al., 2017; Seikkula et al., 2018; Laitila et al., 2019). Interestingly the co-therapists appear to have the highest level of synchrony with each other, highlighting the importance of attunement between co-therapy dyads (Karvonen et al., 2016). Despite the recognition of embodied attunement and the influence of co-therapy on a personal level (Borchers et al., 2013), the processes through which co-therapists manage to tune in to each other and influence each other's presence remain largely understudied.

Using a dialogical loop of co-therapists' interviews and a focus group to increase credibility of the emerging themes around co-therapy, Hornova (2020) revealed that dialogical co-therapy is perceived as energizing for therapists. This might be related to the ability of dialogical practitioners to be themselves in meetings with families, which further creates a feeling of satisfaction (Sidis et al., 2020). Still, to be authentic in voicing the therapist's inner dialogue and emotions can be difficult for health care workers, as this might require an expansion of the professional role (Holmesland et al., 2014). Open Dialogue meetings often challenge practitioners, by demanding a role release and role expansion of their original professional training, i.e., as psychiatrists, psychiatric nurses, social workers etc. (Holmesland et al., 2014). Such

mental health trainings typically encourage developing professionals to be in charge of their emotions and keep them to themselves (Rowan and Jacobs, 2011). Therapists discern meaning based on filters, constructed in different schools of thought and professional trainings. Those filters may block or magnify resonances of therapists with their clients and influence the way they respond to them.

Reflecting on the role of psychiatrists in multi-professional teams, Valtanen (2019) acknowledged the importance of trust and shared understanding among team members. Within a feeling of shared understanding, co-therapists can disagree with their partner. Instead of perceiving it as competition, disagreeing with one's co-therapist is viewed as a way to develop polyphony of equal voices and a way to be authentic (Hornova, 2020). In a similar context, that of Need Adapted Treatment of psychosis with two or more co-therapists present, psychiatrists being interviewed through co-research practices (Andersen, 1997) and stimulated recall interviews (Kagan et al., 1963) recognized that in a treatment situation they are present not only as professionals but also as individuals who share an individual relationship with their co-therapist (Borchers et al., 2013). It has also been found that, when having a personal relationship with one's co-therapist and knowing the personal difficulties they are encountering, therapists are more inclined to perceive their co-therapists as patients themselves and take care of them (Borchers et al., 2013). Although this promotes a safe and friendly working environment, it might present challenges to the roles and responsibilities therapists take on. Creating open spaces for discussions between therapists may help bridge their differences, produce a shared professional identity and cultivate the feeling of safety in the co-therapists' relationship (Holmesland et al., 2014; Valtanen, 2019; Hornova, 2020).

Therapists in an Open Dialogue meeting are not only "hosts" or "guests" of the session but part of the unique encounter of the session, willing to be equally transformed through the therapeutic relationship (Olson and Seikkula, 2003; Brown et al., 2015; Kykyri et al., 2017; Hornova, 2020). This is one of the reasons Open Dialogue trainings include supervision and family of origin groups in their core as a way to appreciate the theoretical underpinnings of Open Dialogue through practice and personal involvement (Putman, 2022a). To be willing to be transformed in a meeting requires self-attentiveness and responsiveness, properties that are cultivated in turn through supervision practices and therapy (i.e., family of origin). It is argued that these requirements of dialogical trainings change and shape significantly practitioners' perceptions of their self and their professional role in therapy (Von Peter, 2019, 2021; Pocobello, 2021; Hendry et al., 2022). Although co-therapy might come up as a theme in supervision and training contexts, not enough attention is given to the relationship of co-therapists, the ways that co-therapists collaborate and manage their differences, and how this willingness to transform might be present and experienced by co-therapists and the network.

In line with Open Dialogue, the present paper follows Bakhtin's (1984) view of the self as polyphonic, comprising of different voices. Developing research reveals the rich inner conversation of therapists during sessions, including attending to client process, processing the client's story, focusing on therapist's own experiences and managing the therapeutic process (Rober et al., 2008). Therapists are invited to attend to all voices in the room, appreciate the horizontal polyphony between network members and the professional team, as well as the vertical polyphony within themselves and each individual in turn (Seikkula, 2008). Co-therapists have an active role in constructing the therapeutic reality as members of the given context and facilitators of the therapeutic process. Following this, co-therapists are not perceived as the experts and their ideas are not imposed to the clients, but they may act as stimuli for change (Andersen, 1991; Rober, 1999, 2005b; Anderson, 2005). As members of the therapeutic encounter, therapists co-create the safe space for the network to unfold their narratives and find words for the not yet said (Shotter, 2011, 2015). In this relational space, therapists' own experience is crucial and may act as a compass to navigate around the multiple voices in a network meeting. Therapists' lived experience involves their use of self, their positioning, body changes, emotional reactions, thoughts, values and beliefs (Simon, 2012; Miller and Baldwin 2013; Avdi and Seikkula, 2019; Gkantona, 2019; Ong et al., 2021; Aponte, 2022). The ways therapists use their experiences is associated with being mindful of their internal process and aware of the influences these may have on the therapeutic process (Rowan and Jacobs, 2011; Mojta et al., 2014).

In order to appreciate the polyphony of their inner voices, therapists need to be attuned to and reflect on both their professional self and their experiencing self (Rober, 2005b; Borcsa and Janusz, 2021). The "professional self," influenced by therapist's skills, training and professional development, takes an observer position and is conceptualized as the inner voice of the therapist that hypothesizes and responds to clients' stories (Rober, 2005b). The "experiencing self," a more intimate self, refers to memories, images and fantasies associated to these observations, drawn from therapists' personal experiences (Rober, 2005b). As the experiencing self is related to therapists' feelings and personal story being evoked during a meeting, it is argued that therapists' own therapy is key in their attunement and use of the experiencing self (Simon, 2006; Clark, 2009; Flaskas, 2009). Through the process of one's own therapy and/or personal growth practices a greater self-awareness and attentiveness is developed (Lum, 2002; Miller and Baldwin 2013).

Therapists' professional self and experiencing self are in an ongoing inner conversation during a meeting, providing different opportunities to respond to their co-therapist's and the networks' invitations and stories (Seikkula et al., 2012; Borcsa and Janusz, 2021). Through alternating between facilitating and reflective positions in the external dialogue with the network and engaging in the reflective processes co-therapists allow the space to each other to attend to their inner dialogue, become more attuned to their inner voices and ultimately be able to develop polyphony (Seikkula, 1995; Rober, 1999, 2005b; Olson and Seikkula, 2003). Differences in therapists' reflexivity and attention to their professional and experiencing selves may influence not only their own presence in a meeting but also co-therapy practice and ultimately provision of care with the networks (Georgaca, 2012; Avdi and Georgaca, 2018). Exploring how the differences between therapists' professional and experiencing selves influence co-therapy can enhance our understanding of co-therapy practice and Open Dialogue network meetings.

Since training in Open Dialogue and dialogic presence have become increasingly popular, it is important that therapists acknowledge those opportunities and appreciate the complexity of the relationship with their co-therapists. The present study aims to contribute to the understanding the co-therapists' relationship and how this relationship influences the individual presence of each therapist. For the purposes of the research the concepts of professional self and experiencing self will be used, to capture part of therapists' inner dialogue and vertical polyphony. It is assumed that if more light is shed into how co-therapists interact with each other while attending not only to their own presence but also to their co-therapist presence as a way to connect and be with

the network, more constructive and supportive practices will be developed.

The research questions are: (a) *How is therapists' professional self and experiencing self present during co-therapy?* and (b) *What are the co-therapy processes that influence therapists' self?*

Materials and methods

Design

The present study aims to examine what aspects of the therapist's self are mobilized during co-therapy, how the therapist's self is affected by co-therapy and which co-therapy processes influence the therapist's self. The study is part of a wider project concerning Open Dialogue practitioners' views and experiences of co-therapy. Two consecutive interviews were conducted with Open Dialogue practitioners, using distinct semi-structured interview guides. The present study was facilitated by the lead author (CL) and the second study, that is still in process, focused on dialogical practices of co-therapists, and was facilitated by the third author (DC). Although the research was done in collaboration, the two studies were analyzed and written separately.

The first author (CL) was completing the 3 years training in Open Dialogue UK at the time and that allowed her access to related practitioner networks. The conceptualization and the interview schedule used in the present study was influenced by the first author's experience of working with different co-therapists and by reflections in the supervision context of the training. The third author (DC) has collaborated with the Mental Health team of Volos, Greece, the first public service in Greece that has been using Open Dialogue informed practices since 2009. The team dynamics and the development of the approach in that context inspired the third author to explore further co-therapists' relationship. Upon completion of each interview the two researchers reflected on their experience and provided feedback to each other for the interviews to follow. The two authors have been collaborating as co-researchers in this process, allowing space for reflexivity and ongoing reflection in the development of the interview guides, approaching participants, implementation of the interviews, and analysis.

Participants

Purposive sampling was used by contacting Open Dialogue international institutes and advertising the research in the closed Facebook group 'Network for Open Dialogue and Reflective Processes'. The selection criteria were that participants had to have completed training in Open Dialogue and have experience working with co-therapists.

Participants were 20 Open Dialogue therapists, eight male and 12 female. According to the professional identities that participants introduced themselves with, eight were psychologists, two psychiatrists, three social workers, one nurse, one peer worker and five therapists did not mention a specific mental health background. It is worth mentioning that often participants' professional roles involved more than the above titles; additional roles included being trainers in Open Dialogue and having administrative positions. Participants worked both in the public sector and in private practice. They came from various geographical locations; 10 participants came from the European Union, five from the United Kingdom, three from the United States of America and two from Australia. Participants' Open Dialogue experience ranged from three to 20 years. They had practiced co-therapy with two to thirty different colleagues.

Data collection

Participants' views and experiences of co-therapy were generated and recorded through semi-structured individual interviews lasting 45–60 min using the online conference platform Google Meet. Before the interview participants completed a demographics form and signed a consent form, confirming knowledge of the confidential and anonymous nature of the data, their right to withdraw and their acceptance to record the interview. In the beginning of the interview the two researchers (CL, DC) introduced each other as co-researchers and allowed time for questions. One researcher would interview and the other was taking a reflective position. Researchers recognized that the one taking the reflective position, waiting for her turn to conduct her research, could engage in the interview if needed. This, however, did not happen at any point of the data collection process. The interview schedule for this study started with questions regarding the ways in which the participants' professional background, namely professional roles and previous training, influence the reflections in a meeting. Participants were also asked what it means to be authentic in a network meeting and how their own personal therapy, personal growth practices, family of origin and other therapies might have influenced that. Finally, there were questions regarding the ways co-therapists support each other to be authentic and respond fully as embodied persons in a network meeting. Participants were encouraged to provide clinical examples for their experiences.

Analysis

All interviews were transcribed, meticulously read, and annotated for important themes and common patterns emerging across interviews by the first author (CL). Thematic analysis was used, aiming to identify themes that capture important aspects of the research question (Braun and Clarke, 2006). All data were coded without trying to test a specific hypothesis, but rather to depict contributors' experiences, applying an inductive thematic analysis. A line-by-line coding was conducted through reading and annotating the first two interviews. Preliminary lists of codes were created, in which codes captured participants' thoughts, experiences, feelings and images on the matter of investigation. Interviews three and four added to the list of codes and created new codes, when contributors' perspectives were new. The same process was followed for interviews 5 to 20. To ensure that the interviews coded last were attended equally to the first interviews, the codes developed were revised many times, reflecting an ongoing back and forth involvement with the data set and coding process. In searching for themes, the codes were listed and grouped based on their commonalities. A name and description were given by the first author to these themes.

Reviewing the themes and adjusting the names and descriptions of themes was accomplished by extensive validation sessions with the second (EG) and third author (DC), who also acted as inter-coders of selected extracts, to promote accuracy and transparency in the coding process. No inter-agreement measures were used in this process; instead, consensual validation and agreement procedures were followed. In each

validation session the first author presented the themes and justified them with reference to participants' quotes. Then through collaborative discussions on differing views, authors reached consensus on the themes best capturing participants' experiences.

The first (CL) and third author (DC) both interacted with all participants of the present study during interviewing, something which allowed them experiential insight into the data collected. They are also both practicing clinicians, and this allowed them a more practice-relevant perspective on the data. The second author (EG) is an academic, experienced in research and initially less attached to the data set. The different perspectives on the same data by the three researchers allowed a variety of voices to emerge when evaluating authors' positions and expectations of the study, while ensuring richness and reflexivity in the process of generating themes (Tong et al., 2007; O'Connor and Joffe, 2020).

As a result of the analytical process, the data were organized into three main themes, namely *therapist's individual presence*, *co-therapy processes*, and *co-therapy as a shared space*, each consisting of different subthemes. In addition, a fourth theme emerged, *trust as a prerequisite*, that connects all three themes.

Results

The themes and subthemes that emerged will be presented and described below, accompanied by representative extracts from the interviews.

Therapist's individual presence

Therapists are present in a network meeting, bringing both their experiencing and professional selves. Having completed a dialogical training, the therapist's presence of experiencing and professional self is already changed following supervision and personal therapy training requirements.

Presence of experiencing self

1. **Use of embodied responses**: The vast majority of participants recognized that part of bringing their experiencing self in a meeting involves being aware of and sharing their own embodied experiences and responses.

> 'My understanding of embodied experience is that it invites us to stay in touch with our mind. […] I can first make a little note to myself that, okay this builds a tension in me and even maybe, digging a bit deeper in that, noticing it, but not maybe feeling that it is a good idea to share it in words, but just noticing and breathing deeper and knowing that it affects my co-worker too, how am I in this moment, how am I holding it in a way' (P8).

2. **Stronger when therapist is self-aware**: It was commonly acknowledged that family of origin, personal therapy and self-growth practices of therapists allow them to be more self-aware and notice their experiencing self in a meeting. Some participants recognized that through their own personal growth journey therapists are more aware of their feelings, vulnerabilities, blind spots, and traumas. A participant commented that this helps to be more humble and curious, not rushing to judge others, as they become aware that all families, including their own, can have '*breakdowns in their communication*' (P15). A different voice emerged from a participant who noted that the mandate of therapists being self-aware may mean that they '*use the power that they are given working in psychiatry and mental health, while exploring their own humanity and experiences on that*' (P10).
3. **Focus remains on the network**: Some participants recognized the importance of self-reflexivity when sharing their experiencing self, talking about their feelings and ideas gently in a way that the network can say no. When they consider that self-disclosure may be helpful for the network, therapists may even explicitly share their personal stories and resonances, and '*connect them to the network's narrative*' (P1). When thinking through the connection between the network's needs and the therapist's experiencing self, one participant noted that co-therapy might not always be the preferred practice for all network members; one to one therapy might be preferable, as a way to explore more private issues and build individuals' confidence.
4. **Involves greater ownership**: Some participants shared the view that through attending to and reflecting on their experiencing self, a sense of ownership is developed that helps therapists '*trust the feeling that is being evoked*' (P14). A participant who is a psychologist stressed the therapist's responsibility toward themselves: '[One has to be] *responsible for their own emotions and ideas in a meeting, and to give voice to them without competing over their co-therapist's*' (P17).

Presence of professional self

1. **Invite professional role**: All participants agreed that the school of thought or training of therapists does not define therapists in an Open Dialogue meeting. They all added that different kinds of professional training are perceived as competences of practitioners and are taken into account when the team is formed, as a way to best adapt to the network's needs. Participants working in multi-professional teams, mainly in the public sector, acknowledged that they often decide on their co-therapists based on their professional background and/or invite other co-workers to consult their network meetings considering their professional background and the needs of the network.
2. **Expertise as part of the polyphony**: Almost all participants recognized that, although part of their contribution to the dialogue may come from their professional role, their expertise, therapists tend to pull back from the expert position and offer all their ideas in a more tentative way in acknowledging that all voices in a meeting are important. More than half of participants used the same wording to characterize working with different therapists of diverse professional backgrounds as allowing for '*horizontal polyphony*', '*richness in understanding*' and '*more opportunities in a meeting*' (P1, P4, P6, P9, P11, P12, P14, P16, P17, P19, P20). Ideas from the therapist's professional self become another voice in the meeting rather than the prominent way of exploring the network's story. Therapists can be more attuned to different parts of an individual's narrative, depending on their professional background, i.e.,: policies around risk.

> 'Part of what I enjoy about doing this work, that I can say - Ah, that's a different approach, I wouldn't have thought about it that way. But sometimes I may say in a reflection – That's really interesting, I wonder what the family members think, we should ask them. - It's almost if I cannot work it out between us, then I will use the family as a resource' (P12).

3. **Stronger when there is uncertainty**: A different voice, expressed by some participants, argued that the presence of many voices may create uncertainty in a meeting. When therapists feel uncertain, they might fall back to a more directive approach, to techniques and understandings deriving from their expertise. They may, thus, return to their professional identity, that is familiar and feels safer to sit with, and '*hear what we have learnt*' (P12).

Co-therapy processes

Participants pointed out specific processes that they engage in with their co-therapists that allow them to tune in to each other and to the network.

Balance through reflection

Most participants acknowledged that the presence of a co-therapist during times of crisis and uncertainty can help tolerate the polyphony and allows thinking about emotions in a more reflective way. Some argued that this allows them to balance their positions and emotions with their co-therapist, by slowing down, sharing their concern and searching for differences rather than sameness in their reflections.

> 'I think having a co-therapist can be very helpful if people become polarized in their position. And I can easily become polarized in my position, so having a co-therapist who can sometimes say - I feel you are stuck where you are, I am not sure what is happening for you - and so being able to challenge each other' (P14).

Invitational language

Like in discussions with the network, some participants saw the language between co-therapists as needing to be invitational, careful, and gentle. This invitational language was considered important for different reasons for each contributor. A few participants argued that when their co-therapist invites them to share the reasons they self-disclosed a personal story or a feeling helps them unfold their thinking, make direct connections to the network and keep the dialogue around the network rather than themselves. One participant said that invitational language allows promotion of trust: '*I have to trust that you are not going to share it inappropriately. And they have to trust that you will not push them beyond their limits*' (P7).

Knowing and accepting each other

Almost all participants shared the view that when co-therapists get to know each other a gentler, more careful and caring attitude toward one's co-therapist is created. In order to be authentic and express their thoughts and feelings it is important that the therapists feel '*sufficiently safe and comfortable*' with their co-therapist (P20). For many participants it was important that they felt unconditionally accepted by their co-therapist, meaning that there were no expectations, no right or wrong ways to be in a meeting. Two participants mentioned that being comfortable refers not only to ways of expression but also to the style of the co-therapist partner, for instance staying in silence or the use of humor. Therapeutic style is distinguished from professional training, as it refers to the way therapists are with people and foster containment. Some participants argued that it might be likely that they cannot work with specific co-therapists, even if they know them well, as co-therapy is a human relationship that, like all relationships, might not work well in particular cases.

Attuning verbally and physically

Getting to know one's co-therapist allows noticing them changing in a non-verbal way during a meeting. Almost half of the participants saw the embodied responses in a meeting as a channel to connect with their co-therapist. A couple of participants mentioned that noticing these embodied reactions in themselves or their co-therapist can be a useful starting point for reflections between co-therapists or an appreciation that someone else has changed in the session, creating more space for the not yet said. A participant said that they sometimes practice mindfulness with their co-therapist before starting a network meeting as a way to "*be attuned to each other" (P7).*

Taking care of the relationship

Dialogic relational spaces between co-therapists outside network meetings were viewed as important by all participants, as they allow deepening their level of attunement with each other. Co-therapists need further spaces to talk about themselves and how it is for them working together. Participants gave different examples of how such dialogical spaces can be created, including before meetings, in supervision or in post session reflections. Almost all participants considered supervision spaces as core in allowing for discussions regarding the relationship of co-therapists. Two participants further acknowledged the need for supervision as a way to discuss how it feels to be challenged, an experience that is quite rare in everyday interactions. Most participants saw supervision practices as a way to avoid competition between co-therapists, which was acknowledged as a threat to co-therapy practice.

> 'We have to make a decision when we are in a network meeting: can we discuss this here, or has something been triggered in us that's too negative, that we maybe have to take to our supervision, because it is something about our relationship, not the family, that we might need to take somewhere else to manage' (P14).

Co-therapy as a shared space

Through those co-therapy processes a shared space between co-therapists is constructed that promotes novel common understandings, a sense of shared responsibility and ultimately a transformation of each therapist's self and practice.

Common understandings based on different perspectives

Spaces to talk about co-therapists' relationship and experience of working together promote a shared attitude toward clients and the network. More than half of participants mentioned that when working with their co-therapists they create common understandings by co-constructing narratives based on each other's experiences, while respecting their differences. A few participants consider those common

understandings as the premise for an open conversation with the network, as they promote safety in therapeutic encounters. For some, common understandings contributed to a feeling of shared hope that things can change for the better. Below is an example of an open dialogue trained therapist collaborating with a drama therapist:

> 'She [drama therapist] was very focused on creating the drama, I suppose, you know the scene. And I would actually introduce a different way of thinking about it. She was setting up a scene for this young man who was quite unwell, to be able to connect with his unusual belief. And the mother was there, as well, and I was able to draw in, What do you think your mother thinks about this or What do you think your father might say about this? So I created a more open dialogue about it, where she was sort of focused on creating the experience for the client' (P16).

Shared responsibility

Many participants recognized that the ability of different professionals to become more flexible and open in a meeting depends on the power and responsibility attributed to them in their training. Some participants viewed psychiatrists and psychoanalysts as being traditionally trained to have greater responsibility and a sense of certainty and knowing during a session. For these professionals, stepping away from the expert position can be quite a step away from their professional training. Most participants agreed that sharing responsibility and believing that co-therapists are in the process of supporting the network together allows the development of open relationships and dialogue with the network. A few participants mentioned that a collaborative non-hierarchical relationship is being formed, that is not based on the therapists' original training.

Transformation of therapists' self and practice

The vast majority of participants saw co-therapy processes and the relationship with the co-therapist as transforming the therapist's way of perceiving their practice as well as their experiencing and professional self. Therapists' professional identity seems to be radically reexamined in rethinking the expert position and recognizing the professional role as one of the many voices in therapists' inner polyphony. In addition, there was overall agreement between participants that co-therapy processes help in opening space for their experiencing self to unfold, as they are being invited to share their lived experience in a meeting rather than just their professional judgment. Not only the way that therapists practice therapy changes, but also the ways they attend to their own inner polyphony is enriched, through their co-therapist's invitations, the reflective processes and observing their co-therapist. Some participants noted that collaborating with a co-therapist who attends to their own embodied experience helps the therapist to do the same, thereby being more attentive to their own experiencing self. '*You are not just listening to words, you are taking everything that is happening*' (P16).

Trust as prerequisite

The importance of trust was recognized for all participants as a prerequisite for the co-therapists' relationship to emerge and unfold. Still, different participants approached it in diverse ways. Some claimed that co-therapists need to hold the space for each other, in a similar way they hold the space for the network. Some participants saw trust in one's co-therapist including knowing that they will respond in a gentle way, while having good intentions. Others considered that trusting one's co-therapist allows their experiencing self to emerge and to be vulnerable in sessions. Some participants conceptualized trust and respect for one's co-therapists as a way to allow tolerating being openly challenged on a professional and personal level. For a few participants having been trained with their co-therapists and having a shared experience in the family of origin group allowed to build a trusting relationship. For almost all participants, co-therapy is perceived as a process that can cultivate trust. In this sense, trust is not fixed in stone but rather is constantly constructed between co-therapists. Greater trust in the relationship between co-therapists allows for increased trust in the dialogical process and in the network.

Discussion

The present study aimed to explore the influence of therapists' professional and experiencing self on co-therapy. It also sought to examine the processes involved in co-therapy and how these shape therapists' selves. As co-therapy is one of the key elements of Open Dialogue meetings, the way therapists' self is implicated in a meeting is likely to impact the collaboration between co-therapists and subsequently the ability to adapt to the needs of the network (Borchers et al., 2013). Participants' testimonies are in line with previous research on co-therapy in the context of Open Dialogue (Borchers et al., 2013; Holmesland et al., 2014; Hornova, 2020) and with theoretical expectations (Valtanen, 2019; Sidis et al., 2020) recognizing the importance of embodied presence, authenticity, shared understanding, shared responsibility, trust, and supervision in co-therapy practice. A unique contribution of the present research consists in highlighting how therapists' individual presence, co-therapy processes and the shared space created dynamically interact inside and outside network meetings. Participants recognized an individual change as a result of a shared situation, making co-therapy a highly dynamic process and a transformational experience.

Using thematic analysis participants' experiences were captured in three main themes. Therapists are *present in a meeting with their experiencing and professional self* (Theme 1). Specific *co-therapy processes* allow co-therapists to tune in to each other verbally and physically (Theme 2). Through those processes a *shared space* is constructed that promotes new common understandings, shared responsibility and ultimately a transformation of each therapist's self and practice (Theme 3). As illustrated in Figure 1, the quality of trust is woven throughout those themes, making trust a prerequisite for therapist's individual presence, co-therapy processes and the shared space to unfold.

Research on therapist's inner conversations during family therapy sessions with one therapist reveals the importance of therapists being attentive to their professional and experiencing self, as a way to respond to the families and create space for the not yet said (Rober, 2005a). Participants recognized that their experiencing self is present through their embodied responses and is stronger when they are self-aware. In line with previous research, self-growth practices, including personal therapy, family of origin, meditation etc., are critical for therapists to be aware of their own vulnerabilities and blind spots (Lum, 2002; Clark, 2009; Rowan and Jacobs, 2011; Ong and Buus, 2021). This helps them to keep the focus on the network and to make decisions regarding what voices of their experiencing self can become public or are worth exploring in different contexts. Weingarten (2010)

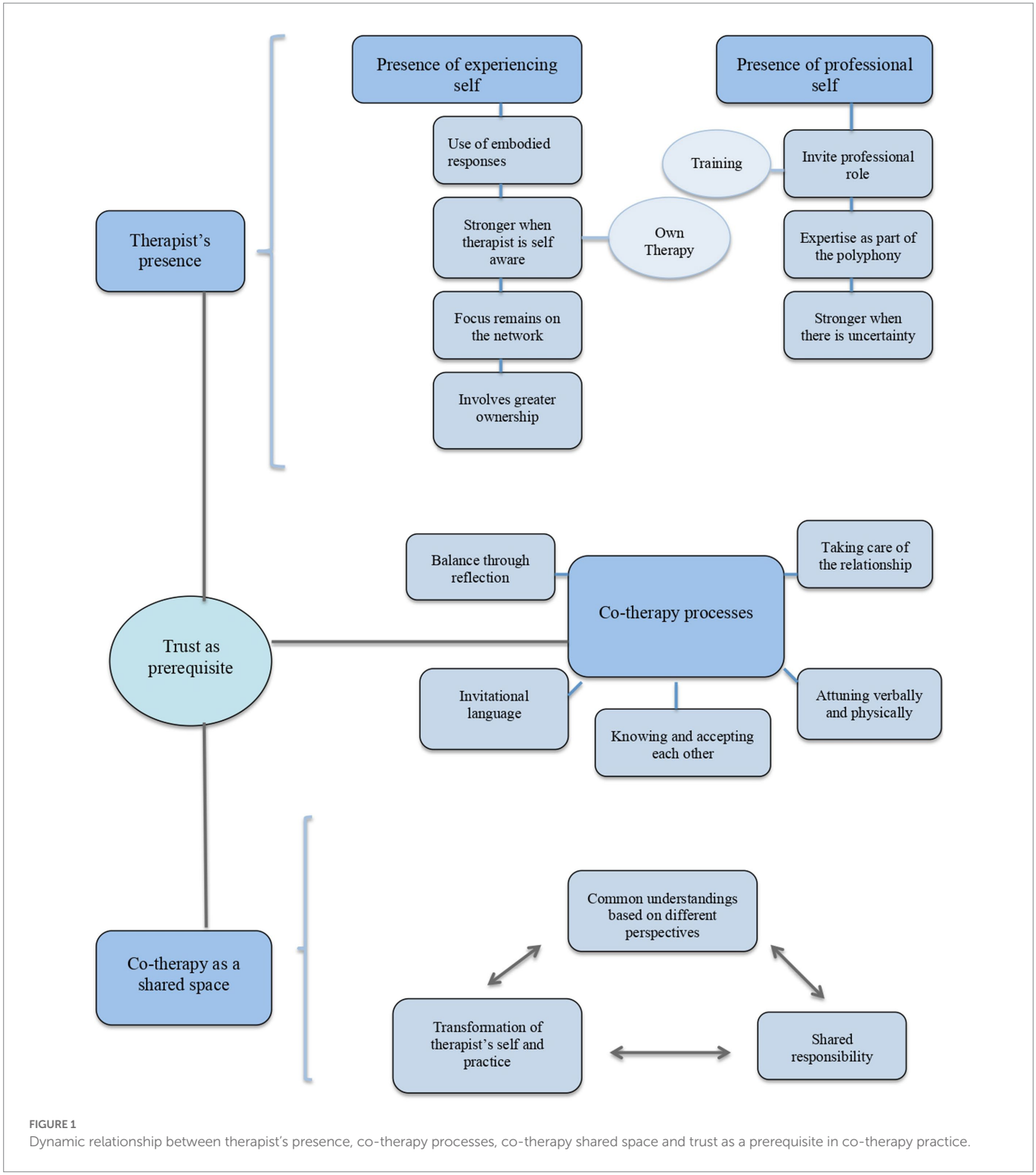

FIGURE 1
Dynamic relationship between therapist's presence, co-therapy processes, co-therapy shared space and trust as a prerequisite in co-therapy practice.

suggested that this ability of therapists to be self-aware is accompanied by a sense of empowerment. In line with this, a participant in the present study said that bringing in the meeting one's experiencing self involves greater ownership of their feelings and emotions. Sharing one's emotions is not typical in traditional mental health trainings (Rowan and Jacobs, 2011), while there is an ongoing discussion about the opportunities and threats that come with self-disclosure and transparency in the field of family therapy (Roberts, 2005). Being more self-aware, through various practices, therapists develop a sense of owning their emotions and greater confidence, in that their remarks do not always have to be "right" but can come from the heart (Seikkula and Trimble, 2005).

The professional self, in terms of one's professional expertise, is often the reason why specific practitioners are invited in meetings with networks. Still, all participants acknowledged that their professional self becomes another voice in the polyphony. This might explain why there

were no differences in participants' experiences of co-therapy despite their different original professional training. Similar to Hornova's (2020) findings that co-therapists' practices change in times of pressure and crisis, participants recognized that the voice of their professional self tends to be more dominant in times of uncertainty. Instead of viewing this uncertainty as a shared, overwhelming, experience of co-therapists, it seems that therapists opt for giving voice to each therapist's concerns in turn. Breaking down therapists' concerns is likely to make it easier to work through them and promote more opportunities for dialogue with the network. Specific co-therapy processes might help therapists regain trust in the therapeutic dialogue.

Participants repeatedly argued that what shapes their collaboration with their co-therapist is the personal ways of being with them, rather than their co-therapist's professional background. Several co-therapy processes were mentioned. Co-therapists tend to balance each other through reflecting openly on their ideas and concerns. This is in line with literature suggesting that allowing time for reflection helps therapists not getting stuck in one position (Andersen, 1991, 1997; Borcsa and Janusz, 2021). Co-therapists can invite their co-therapists to unfold their thinking and share the reasons behind asking particular questions, addressing their professional self and the ways their stories may resonate to the networks' narrative or addressing their experiencing self. It seems that using a language that focuses more on emotions and personal resonances rather than a language that tends to be dissociative and descriptive can further promote self-reflexivity and body-awareness for the therapist and the network (Hornova, 2020).

Knowing one's co-therapists was acknowledged for most participants as key to being present in a meeting and attuning to each other in their embodied presence. This is in line with the limited research on co-therapists' views of team meetings (Borchers et al., 2013; Holmesland et al., 2014; Hornova, 2020). Attention needs to be drawn, however, to the responsibilities that come with this familiarity (Borchers et al., 2013), as therapists might try to protect their co-therapist and/or avoid specific themes in a meeting that may be sensitive for their co-therapists, at the expense of the families' exploration of alternative narratives. Future research needs to study further the challenges that come with therapists' collaboration and familiarity.

Creating spaces outside the meeting to explore how it is for co-therapists to work together is key, as those spaces allow co-therapists to take care of their relationship, through exploring ways of being together. Supervision and the need for training have been widely recognized in the co-therapy practice in Marriage and Family Therapy research (Hendrix et al., 2001) and in Open Dialogue research (Hornova, 2020). Participants in the present study defined supervision as a space to explore ways of being with their co-therapist and develop opportunities to hold the space for each other, rather than as a way to discuss about the family and/or develop alternative hypotheses (Hendrix et al., 2001). Having such spaces to reflect on what co-therapists draw from the conversation with the network and how they want to address their co-therapist and the network members is critical for the creation of a safe therapeutic space and dialogue. Administrative and organizational structures need to protect co-therapists and provide the spaces for such dialogical and supervision practices, so that these become a learning experience for both the individual therapists and the co-therapy partners. This can be provided by service administration in the public sector but can be more demanding and costly in the private sector. For therapists working in the private sector greater initiative and commitment is required in offering themselves the supervision and reflective space to take care of the co-therapy relationship.

Through these co-therapy processes of balancing through reflections, taking care of the relationship, attuning verbally and physically, knowing and accepting each other and using invitational language co-therapists create a shared space that involves common understandings based on different perspectives. These common understandings contribute to the sense of shared responsibility between co-therapists and link back to two of the main principles of Open Dialogue meetings, namely allowing for responsibility and psychological continuity. Although sharing responsibility allows more flexibility in a meeting to explore feelings of curiosity and tolerate uncertainty in times of crisis, it may demand a role-expansion for some professionals (Holmesland et al., 2014; Hornova, 2020). Like all experiences involving change, one's emotions are mixed, involving, among others, a sense of curiosity for the newness to come and a feeling of loss for what one leaves behind. Following participants' testimonies, we propose that co-therapy can act both as a stimulus for such a transformational change and as a secure base to explore the multiple, often conflicting, feelings that accompany it.

Responsibility becomes a relational quality that is reflected and reflects in turn in the ways co-therapists are with a network (McNamee and Gergen, 1998). Creating a common understanding is very much based on co-therapists helping and inviting each other to openly share their thoughts and experiences, rather than competing with one another. Most importantly, it can be the case that if a therapist has not followed their co-therapist's remarks, neither would the network members. Allowing the space to understand each other promotes the feeling of safety that therapists and network members are all in the therapeutic process together, having a shared language (Valtanen, 2019), which in turn contributes to the relationship between therapists and network members (Friedlander et al., 2006, 2011) and ultimately good therapeutic outcomes (Fife et al., 2014; Davis and Hsieh, 2019). This is in line with participants' recognition that having common understandings with their co-therapist is the most important predictive factor for good outcomes in sessions.

In comparing poor and good outcomes of Open Dialogue, good outcomes have been associated with increased dialogical responses, compared to monological ones, in network meetings (Seikkula, 2002). As a therapist, the ability to promote dialogue depends not only on the training but most importantly on one's dialogical personality (Brown, 2012; Reed, 2013; Brown et al., 2015). Cultivating a dialogical personality cannot solely rely on skills and techniques, but rather requires time and self-exploration to be accomplished; in this sense therapist's dialogicity cannot be taught but can be learnt. Considering that Open Dialogue meetings are co-facilitated, this dialogical personality must be perceived in the context of the relationship with one's co-therapist, rather than as an isolated personal characteristic. There has been some discussion around this transformation in dialogical literature, mainly concerning the ways practitioners perceive their professional identity and their expertise (Von Peter, 2021) and being authentic in voicing their feelings and emotions (Seikkula et al., 2012; Holmesland et al., 2014; Hornova, 2020). Drawing on all themes that emerged in the present study, participants highlighted that when working with a co-therapist the therapist's inner conversation has an additional level concerning how their co-therapist responds to what is happening and how to use the space with the co-therapist to reflect on their own experiences. In this way co-therapy promotes a more dialogical personality and allows the therapist's own transformation. This transformation enriches the positions of each therapist's self in turn and allows for common understandings and sharing of responsibility.

Limitations and recommendations

Apart from some research regarding co-therapists' experiences of dialogical co-therapy (Hornova, 2020) and some empirical evidence on psychiatrists' experience in teams with co-workers (Borchers et al., 2013), to our knowledge this is the first study to explore the professional self and experiencing self of therapists in a multi-dialogue context and their influences on co-therapy. Rober (2005a, 2017) studied therapist's experiencing self and professional self using interpersonal process recall interviews, that are closely examining the therapist's inner conversation retrospectively, 24 to 48 h after a meeting. The present study operationalized the professional and experiencing self differently, by following therapists' own stories, experiences and meaning making of their professional role and lived experience in a network meeting. This might produce some discrepancy in the conceptualization of the different aspects of the self. It would be worth exploring the interplay and inner dialogue of co-therapists after an Open Dialogue meeting using interpersonal process recall interviews or semi-structured interviews with the co-therapist partners and explore if similar or different themes emerge.

Another limitation of the present study concerned the unbalanced number of participants' professional backgrounds. There was an over-representation of psychologists in the research, only two psychiatrists, one psychiatric nurse and just one peer worker. Concerning the underrepresentation of peers in particular, there is a growing literature on the participation of peer workers in Open Dialogue meetings (Nelson et al., 2022; Osborne, 2022; Razzaque et al., 2022). Peer workers sharing aspects of their lived experience and voicing more of their experiencing self might draw different attention to the influence of professional and experiencing selves of co-therapists. This would be worth exploring further.

Although, participants recognized the value of allowing time to reflect on their relationship with their co-therapists, it would be of great interest if future research studied together co-therapists' experience of their relationship in joint interviews or in a focus group. Reflecting together on their relationship was something suggested by some of the participants. A further insight in the dynamics and transformational value of co-therapy would come from networks' perspectives on their co-therapists' relationship and presence, through the use of questionnaires or an open conversation on "how we experience our co-therapists working together."

Conclusion

Co-therapy contributes significantly to the development of therapists' professional self and experiencing self. Through various co-therapy processes, therapists support each other to attend to, unfold and share different voices of their inner dialogue with the network. It is easy to get stuck in one position, inspired by learnings of the professional self or by memories of the experiencing self. Through co-therapists' invitation of one's different voices therapists can make these voices less demanding, allow to move around different ideas and develop polyphony. This transformation of co-therapists in repositioning themselves as polyphonic individuals is reflected in the dialogical presence with each other that is not predetermined by their professional roles. Co-therapy can be a shared space for co-therapists to explore their differences and disagreements together, until something new emerges. This is how dialogue becomes healing.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The study was reviewed and approved by Open Dialogue UK. The participants provided their written informed consent to participate in the study.

Author contributions

CL: conceptualization and original draft preparation. CL and DC: literature review. CL, EG, and DC: methodology, formal analysis, writing-review and editing. All authors have read and agreed to the published version of the manuscript.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Practitioners of open dialogue report their personal transformations as a result of conducting network meetings

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As health care providers practicing Open Dialogue, we cleave to the notion that the support we provide to users and their communities will lead to the kind of enduring personal transformation that *they* would consider an improvement. But what effects do Open Dialogue network meetings have toward instilling enduring personal transformations within the practitioners themselves? This subject is rarely addressed, particularly in academic settings. In this autoethnographic account, an experiencer/occupational therapist, a marriage & family therapist, and a psychiatrist each describe enduring transformations that they attribute to working together as Open Dialogue network meeting facilitators at one stand-alone clinic over 2 years. Our report illustrates the potential of Open Dialogue network meetings, particularly the depth and breadth of transformation that can occur in *all* who attend them.

KEYWORDS

collaborative-dialogic approaches to mental healthcare, practitioner personal transformation, Open Dialogue network meeting, dialogical supervision, mutual transforming

Introduction

Like other post-modern approaches, Open Dialogue predicates second order cybernetics: In the act of observing and engaging with others during therapy, the helpers are inevitably changed by the process. There has been much care and attention given to exploring the allowing for, and the assimilation of utterances by clients during therapy (Anderson and Goolishian, 1992). The internal dialogue occurring *within* practitioners has also received attention often in the form of a microanalysis of therapy sessions *post hoc*, largely centered around the internal dialogue as recounted after a particular session with the help of taped recordings (Rober, 2005; Seikkula et al., 2012).

In our report, we explore the enduring transformations occurring within ourselves as practitioners attributing these transformations to our work with clients. In some

ways this is new territory (Kahn and Fromm, 2001; Råbu et al., 2011; McNamee, 2015; Hirschhorn, 2016).

Such transformations deserve greater scrutiny since it is difficult to accompany clients in their journey any farther than we as practitioners have progressed in ours. Further, Carl Jung writes: "...the meeting of two personalities is like the contact of two chemical substances; if there is any reaction, both are transformed" (Jung, 1933).

In this autoethnographic account, an experiencer/occupational therapist, a marriage and family therapist, and a psychiatrist each describe enduring transformations that they attribute to working together as Open Dialogue network meeting facilitators at one stand-alone clinic over a two-year time period. Our accounts are as follows.

Deb's words

My primary response to being trained in Open Dialogue and participating in network meetings has been one of profound relief. Relief that I am not the only one who thinks this way, who wants to do work with others in this way, and who gets satisfaction out of using an open and supportive approach (Morasse, 2015; Sandmaier, 2019).

I am trained as an occupational therapist, having worked primarily in psychiatric settings, I also learned in my late 50's how much of my experiences have in common with experiences labeled "psychotic," and I found the psychiatric survivor movement. After that, I began training in Open Dialogue and fell in love.

Prior to learning how to work dialogically, professionally I had frequently struggled with the admonition to keep strict professional boundaries between my personal experiences and my professional role. While I could see that some sharing on the part of providers could lead to the focus coming off the person with the concern, I also knew that sharing oneself with others was a necessary requirement for developing relationships. I couldn't understand why a professional relationship would be any different. As a young therapist with only a small amount of direct supervision, I realized that when I kept strict "professional boundaries," this interfered with my ability to develop rapport with my clients.

Early in my career, I was shocked when one client told me they could share with me *because* I had crossed boundaries and shared my struggles. I then realized that careful sharing of my real self was actually more effective in helping to support behavioral changes than "treatment as usual." The client was better able from my examples to understand the concepts being addressed and this then allowed them to act on those concepts to make changes to their own behavior. I began to notice more "aha!" moments in my clients when I shared, as opposed to when I did not. Indeed, the more frequently I judiciously shared my authentic experience, the stronger the bonds with my clients became and the more effective my interventions were.

This is consistent with polyphony, where all "voices" are welcome, whether they be internal or external, from client or professional, spoken or visual or behavioral. In network meetings, I experienced a sense of "opening" and interest when I spoke of my own experiences. One client in a network meeting spoke of his auditory hallucinations and then of feeling lonely. I asked if he wanted to meet people who also heard voices, and he agreed. His face lit up when I shared that I heard voices and offered to share my experiences with him.

I am incredibly moved by the interactive dance of words that takes place in network meetings. In training, I was taught that the professionals can ask to share their reflections with the clients. One family consistently requested that the professionals to share a reflection on what had just been said. It is not the "usual" or "expected" response, but in Open Dialogue, it's all part of the conversation–there is no "one right way."

After training and participating in network meetings over the past few years, I've noticed that my approach to conversations in therapy sessions, network meetings, and "real life" have changed. I am more likely to truly listen to what is being said without rehearsing my response while another is speaking. I seek to acknowledge with the person that I have understood them before going on. I am much more likely to ask a question than to respond with an answer. I more frequently bring curiosity to the conversation: What do you think about that? I wonder why (something happened)?

Personally, I feel more comfortable in social situations. I am much less likely to feel I need to say the "right" thing and I am more open to being in the moment and enjoying the conversation.

Professionally, I am more comfortable in sessions now that I can let go of having to be the "expert." I enjoy the atmosphere of shared experiences rather than the traditional inequality of the professional's (assumed) expertise as opposed to the (assumed) incompetence of non-professionals. This approach demonstrates respect for all in the room; it feels more intuitive and genuine, and it is almost uniformly acknowledged by the participants as being of value to them.

I feel honored to be in network meetings to witness and support participants in being their own genuine selves. By witnessing and accepting others in the context of network meetings, I have found I'm more likely to provide myself the same care and compassion that I give to clients.

Fletch's words

Much of our medical training, including psychiatry, centers around pattern recognition and applying treatment algorithms. We identify one or more diagnoses best fitting a constellation of symptoms followed by the adherence to treatment algorithms

most likely to manage maladaptive behaviors in favor of adaptive ones. Arguably, a change toward adaptive behaviors is an orthodox standard of successful treatment (Coulacoglou and Saklofske, 2017). During our training as physicians the notion that positive personal transformation and attendant adaptive behaviors occurring in the clinician during the treatment of others is rarely discussed. The main interface between practitioner and patient within the Open Dialogue approach is the network meeting. In this context, I offer the following vignette of such personal transformation.

Over nine months' time, the three of us (DA, FT, and AT) facilitated a series of network meetings, about two a month, involving an extended family concerned for a member, 25 year-old "Tom", who said he had been hospitalized several times for paranoid schizophrenia. Accompanying Tom were his mother, father, four siblings, and his wheelchair-bound maternal grandmother. I was struck by the affectionate banter across three generations as well as their animated discussions on how to best support Tom as he struggled with self-care while alone in his apartment. There were times when Tom would storm out of the room, but he usually circled back a few minutes later after a smoke, having sorted himself out. We each commented at different times about the tension between he and his mother, how their conversations seemed stilted and awkward. When addressing this, Tom said he could not talk about it. Finally, during one meeting 3 months after beginning, the subject came up again and he turned to his mother and spoke: "Mom, you tried to poison me when I was 6 years old! Remember?"

The mother was mortified and said "I would never do that. How could you possibly think that I would do such a thing?"

"And why did you try to do a mind wipe?" He added.

The family struggled to reconcile these two vastly different versions of their history together. Each of them talked about their experiences around that time. Over the next few months, they all continued attending meetings, yet around this one issue there was never any literal/verbal reconciliation.

Later, someone reflected aloud: "I wonder what it's like for mother and son to keep meeting together, to talk to each other when one is sure that the other has poisoned him?"

During and after the network meeting experiences above, I began to think how I could nudge myself toward an acceptance of the multiple realities within my own family members while still adhering to my core principles and sanity. I have a family member who in the home of my youth, as an adolescent, he had sexually abused another younger minor family member. For years, the perpetrator accused me of the offense that he alone committed. No one believed him. I held him in contempt, barely speaking to him for years.

For years, I had ignored his repeated calls and held him at arm's length. Following these network meetings, I began answering his calls and we began to have tentative conversations about life. We met for lunch one day and we wound up discussing fatherhood. I watched myself listening to his concerns about raising his adolescent child while trying to set aside the deafening roar of my anger at his betrayal. Since then, we have become closer.

Thanks to Tom's family and others like them, I have found within me a greater capacity to tolerate the viewpoint of someone whose stated realities and motives are not completely known to me. It is possible to set boundaries, respectful ones, while keeping open lines of communication with the understanding that we may never in this lifetime agree on some of the most basic things. If this kind of relationship is possible with a family member, it is possible with anyone.

My relationships with everyone have shifted in the direction of my possessing a more open mindset when others speak of their realities. I can listen to somebody's opposing point of view and still hold firm to my most basic core value system. Somehow, as a result, I believe I have also become a bit less prideful. These are among the changes I have noticed since participating in the facilitation of Open Dialogue network meetings.

Alita's words

A career, if you're lucky, should be something one endeavors with somewhat of a significant level of interest and engagement—that one can practice one's own true nature, and perhaps even more wonderful, one's own values. Psychotherapy/counseling was something I fell into as I joined my high-school on-campus peer counseling team at age 16. Talking to peers when they were in crisis seemed important and needed, something I thought I would want available for myself. So then, a "Judeo-Christian" value I was brought up in—you might say—"to treat others as you would like to be treated"—should not I make myself available to others in this way? I did. It led me to choosing to study psychology, thinking that in this way I could become a part of others' healing; maybe even on a "soul" level. "Psyche" does indeed translate to soul. In my training, mental health practitioners are encouraged (and need I say it's necessary) to do one's own work in order that one learn to be present, capable, aware, and "do no harm," as much as possible. I cannot control systems at large that govern the policies of mental health guidelines or implementation—(not directly or alone anyway). That said, I *can* continue practicing my values within the scope of psychotherapy, and even more so, I have found that to be the case by participating in network meetings.

Learning and practicing Open Dialogue, if I can even say it's such a "thing," {*rather, it's an attitude or an idea held lightly; of doing less and "being with" more [as in a "benign expertise"* (Minuchin, 1998)]} has been something which in my career has, in a way, helped me to be more in myself and of myself *with* others at the same time. Promoting dialogue requires quieting oneself, leaving room for pondering, embodying an invitational silent presence for others to question and struggle together, to decide together how to go (Shotter, 1993). Dialogical practice

cannot happen without my participation. It can also not happen in many moments when I attempt to control the outcome. This is (though arguable), philosophically, ontologically, for me, the *most* important. Dialogical practice *not* being about controlling the outcome is a transformative understanding to remember over and over, and over again with each family, each group/couple/business/team/meeting—that my *own* attempts to control or to be in charge of what *should* happen *when*, are not so much in dialogue with others.

We are human and we are born in dialogue, with nature, with other living things, and I cannot be unmoved. Open Dialogue network meetings are the medicine, not the doctor giving something to ail something wrong—we are co-creating space for language and understanding to emerge in its own way, and to be a witness, and to bring my body, attention, and time to be with the flow of the sharing of ideas. This is a radical way of being and also the most basic (McNamee, 2015).

I feel tremendous relief when co-facilitating network meetings because I don't bring agenda, goals, needs for anyone to get better or get over some symptom. I keep my training in the background while attempting to stay fresh with each moment. This is how I would want to be met in crisis, and so I do my best to offer and create ways that network meetings can become standard for mental health healing endeavors. Transformation itself, too, is a living process, where my own changing is never done. Before calling myself an Open Dialogue practitioner, I might have thought that somehow there was an end to healing, that somehow my helping profession was solving something or someone, getting them "better." I cannot unknow this collaborative-dialogical practice now. I carry lightly the helper role, remaining invitational to contexts, dilemmas re-naming themselves, allowing situations to be incomplete, placing the expert to be there between a person and their network themselves (i.e., the expert is *the relationship between a person and their network*). I have begun to learn what humility is, realizing that much of my career in emergency psychiatry *did* do harm, now, in offering and teaching others the history and practices of Open Dialogue, there might be, maybe, some reconciliation, for myself, and others, at the same time.

Thinking back over the start of my career serving psychiatric populations, I recall many times where I participated in care within a hospital setting where procedures and decisions made privileged the ease of systems and policy instead of the motto seen on posters about the hallways "*PATIENTS FIRST.*" Suffice it to say, "CYA" very often won out instead of us (hospital staff) risking to do what was called for, albeit inconvenient. Sometimes these memories flash before me, and there exists in me some sort of guilt, maybe for how I might have been seen by the eyes of colleagues, or acting from a place of fearing a bad work review or fear of losing my job if I stood up for the inconvenient patient's way. I walked a narrow line at times, dare I say I buried this moral injury, some kind of by-stander effect, being a part of a system where human rights were not always honored, I tried to serve patients and their families, while feeling I had my hands tied behind on my back. It took a toll. Enter "open dialogue."

Now in my own small practice, I still feel that guilt at times, or maybe it is pain, or lament, grief, for the so-many-others across time who've been met with fragmentation, disengaged from dialogue. And so how is one to be in dialogue with that? When I participate in the utterances of others in the meetings which I am a part of, truth emerges announced; dialogue is when there is a stream of meaning flowing among and through and between us (Bohm, 1996). How do we stay in that stream? I stay in it because not being in dialogue now feels like death. I want life. I want to live. Even if it is difficult, even if there is confusion about what I do or how a meeting will be, or how some care for a patient including a complicated network goes, it is alive, and it is dialogue, and I am open. Even to the strange or peculiar. Perhaps in the postmodern era of helping professions we will find in madness the wisdom that people of earlier ages found (Foucault, 2009).

Conclusion

In the context of Open Dialogue network meetings all three of us practitioners attributed our personal transformations, at least in part, to what happened during network meetings. We agreed that our internal changes were profound enough to change our mindset and our behaviors, though our transformations themselves varied. We share our accounts in hopes that other practitioners, in making room for other voices, will continue to allow themselves to also be changed by them. The three of us were able to share these awarenesses for several reasons. The training that Deb and Fletch attended was presented in such a way as to encourage and allow this kind of self-reflection: we were encouraged to bring our own processes to discussions during the training itself. Inter-Vision (*our regular sessions together outside of network meetings which was a peer-based supervision/consultation format run dialogically*) allowed for further discussion and reflection among ourselves in an accepting and supportive environment. We were willing and available to have transdisciplinary conversations versus defending our own individual professional turf.

In conclusion, our participation in Open Dialogue network meetings has had a significant positive impact on each of us, professionally and personally. Deb significantly increased her scope of confidence in using open and supportive approaches and also was able to improve her own inner dialogue and be more helpful and understanding to herself. Fletch has used skills learned in network meetings to inform his professional approach, and has changed one family relationship from one of animosity on his part to being able to tolerate the vast differences between them and still be true to his own values. Alita has been able to let go of a sense of control to better support clients and to better live in alignment with her own values and ethics.

Network meetings can have a profound effect on all participants including the practitioners. We understand that one limitation of our autoethnographic accounts is how to reckon their applicability to the lives of other practitioners. As open dialogue service throughout the world continues to develop, further research on clinicians' experiences in network meetings could lead to positive outcomes research pertaining to staff retention and quality of life in service systems, patient improvement and treatment satisfaction, and potentially to the reduction of burnout in the field of mental health in general. Ongoing dialogical supervision meetings and trainings are continuously needed to share our insights and new understandings for how practitioners find themselves changed in the process of conducting network meetings (Marovic and Snyders, 2010) remembering that transformation is a process; there is no end to our changing (Kunitz, 2007).

Data availability statement

The original contributions presented in this study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

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All authors listed have made a substantial, direct, and intellectual contribution to the work, and approved it for publication.

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Using Open Dialogue-inspired dialogism in non-psychiatric medical practice: A ten-year experience

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Introduction

Physicians are frequently consulted by people with physical symptoms that, after having ruled out an "organic" pathology, we suspect they are related to the most frequent psychological conditions in the usual consultation: the various forms of reaction to severe stress (Acute Stress Reaction and Adjustment Disorder, from ICD 11), "functional" pathologies, burn out syndrome, and anxiety disorders, especially Generalized Anxiety Disorder, with or without associated depression.

They are usually given a brief explanation about these problems and how they affect their health, given a brochure, or suggested a website with information. And then they are encouraged to visit a mental health practitioner. But there are some challenges to this seemingly simple scenario.

The patients' confusion

Not all patients are ready or willing to hear that their health problem might be related to their life or emotions. Many are strongly influenced by mind-body dualism. Others have an intuition that such a relationship exists but bringing that to consciousness is not an easy process, because it can awaken emotions that are difficult to handle.

This is quite frequent in people suffering chronic anxiety (DSM-5 Generalized Anxiety Disorder) who prefer to consult medical providers rather than psychologists (Wittchen et al., 2002), because they do not consider their constant and excessive worry to be related to their discomfort. In their worrying they are hoping for a straightforward solution. Often these patients ask the physician for "solutions" to their symptoms in the form of medical treatments and they feel uncomfortable if one suggests there is a connection to their emotions.

The doctors' confusion

We physicians know that listening to our stressed, distraught, or depressed patients is a noble and humanitarian task. But we are not convinced

whether that listening has a real and proven effect on the patient's health. In a system that measures the "efficiency" of medical work by other parameters, and that increasingly takes more and more of our consultation time, listening tends to be overlooked. One usually asks general questions (verbally or through a questionnaire) about the level of stress, anxiety and depression, and then gives over-all information about these issues. But we don't know if one should ask about what is going on in their lives more specifically, moving from questioning to dialogue. Concretely, there are dilemmas that persist:

- Why, by what means does a conversation help the patient?
- Is this the competence of the physician or the psychologist?
- Is there a border or limit that should not be crossed?
- What should we "do" with all this "information" they are giving us?
- What does the patient really need from us when he/she tells us something personal?

To a non-physician reading this paper, these questions may seem weird. But physicians, in our medical training, have received different answers to these questions. Sometimes the teachers adhered to the theory that listening is something so complex, the human mind such an intricate and unconscious "mechanism of drives," that it would be best not to enter such dangerous terrain and leave the task to the specialists. At the other extreme were those who proposed humanizing medicine, revaluing the doctor-patient relationship, empathizing with the patient… but these statements fell into vagueness and idealization, with no concrete way of putting them into practice, nor of verifying their efficacy.

Patients in a spiral that progresses to grave consequences

Patients often come to the consultation in a strong emotional state where confusion, fear and discouragement predominate. They may not understand what is happening to them, and their thoughts are full of catastrophic anticipations. They suffer multiple discomforts due to the neurohumoral activation of stress: cardiovascular symptoms (hypertensive crises, tachycardia, shortness of breath, fainting), digestive symptoms (dyspepsia, gastritis, irritable bowel, etc.), dermatological and muscular among others.

They tend to dissociate physical symptoms from their emotional state, and this may generate a transitory benefit, but it ultimately increases their discomfort. They begin to believe that they have an uncertain and capricious pathology, which medicine can no longer decipher. If the physician restricts to prescribing drugs for each of these symptoms, a patient may leave the office with an endless list of medications that will have little effect. But most damagingly, it has reinforced the patient's belief that he/she is suffering from a "disease" in the most organic sense of the word.

If physicians do not have an appropriate conversation with these patients, it ends up creating a vicious circle: the worse the emotional state, the more physical symptoms are generated, creating a downward spiral. Often a depression secondary to stress appears, or preexistent conditions are exacerbated.

A task that cannot be delegated

The psychologist is not responsible for providing medical information and clarity: it is up to us to explain the relationship between the autonomic activation of stress response and the emotional state. To confirm that the symptoms are an adaptive reaction of the body to stress, and not an "illness" on its own. In the case of these patients, the figure of the physician carries a lot of weight, a lot of power. I work together with psychologists and psychiatrists and many of my patients end up consulting them. But this first approximation is my responsibility. The physician is the bridge between the biological and the psychic world, the one responsible for breaking that harmful circularity. Nobody can do it for us if we don't. And doing so should not be optional, but part of the medical act, because the consequences can be serious.

Discussion

It is also possible to conceptualize these patients' condition from a dialogic perspective (Hermans et al., 1992; Hermans, 2001; Seikkula, 2005; Antoni, 2022) where internal and external dialogicity are interrupted, and a monologic voice has taken control of their lives and suppressed other voices. For instance, a mother who suffers frequent severe hypertensive crises finds it difficult to relate this to the worry generated by an addicted child, or a violent intimate partner relationship. These are subjects triggering strong emotions and it is difficult to talk about them with others… but mainly with herself.

This woman's fear, anger, or exhaustion are present, but may be unlikely to surface in her consciousness, if the voice of the self-sacrificing mother or the devoted wife dominates the scene and becomes monologic. Denial or unawareness can function as a refuge from difficult-to-manage emotions, but this interrupted dialogicity occurs at the cost of great inner tension, that finally emerges as physical symptoms.

A dialogic way of listening stimulates the emergence of a polyphony of voices (Bakhtin, 2013) and emotions. External speech simultaneously activates inner one (Vygotsky, 1977; Riviere, 2005), the speech we use from childhood to order our conscience and regulate our actions. That allows "the speaker to inform his interlocutors on his

experiences and at the same time shapes them and is more aware of them" (Seikkula, 2006, p. 102). In this way "speaking is an action in which the speaker allows himself to understand what he has said means to him" (p. 102). New meanings appear, alternative conceptualizations to the dominant narrative (Bruner, 1986, 1990; Charon, 2006).

The listener tries to respond to each word that is said, following the principle that the full sense of a sentence is reached with the response of the listener (Bakhtin, 2010; Seikkula and Arnkil, 2014). And as "symptoms inhabit emotions in the broad sense, in embodied emotions," likewise "the new language arises also in experiences in the broad sense, in embodied experiences, and not in rational explanations" (Seikkula, 2006, p. 103).

Concretizing dialogism in medical practice. First moment

Our first intention is also to listen to the patient in such a way that he/she begins to listen to him/herself, thus shaping his/her thoughts. Along with that, new voices and emotions appear, and more awareness and new meanings are generated.

In an initial moment or phase, where dialogic listening is paramount, I use resources such as reflections, affirmations, open questions and short summaries (Rogers, 2012; Miller, 2013). However, the most important resources are non-verbal: having eye contact, our body posture, and generating silences that lead the patient to think that what he or she is saying is clear, we understand and validate it.

I understand dialogicity as the situation that facilitates the emergence of the conditions of new insights, in a relational context. More than a means to produce new ideas, it is an integral human situation, where we intervene with all our corporeality and emotions. To dialogue is, above all, to help to create an emotional climate, where the patient feels confident to evoke difficult voices and see new alternatives. If this does not occur, everything remains on a rational level, as Seikkula says.

This requires the physician to participate in a less structured way than usual. Says Seikkula: "By responding as whole people, team members manifest that they are moved by the emotions in the room. Their calm and respectful conversational movements have a rhythm that allows them to fully experience and express the feelings in the meeting." (2005, p. 466).

Second moment

When patients have been able to speak, be heard and responded to; when they are more aware of the inner voices and the tension between them—the emotions involved-, then it is the physician's turn to give information. This is a second moment, so to speak. The doctor may explain the effects that emotions in general have on the activation of the neurohumoral stress response, and its expression in physical symptoms. The intention here is not to close or culminate the conversation, but to generate more dialogue based on this new information. I ask them: what do you think about what I have told you? Would you like to comment on it? And that always triggers new voices, more dialogue.

The physician's main objective for the patient is to find a relationship between these three factors: its own new polyphony of voices, the tension between them -the resulting emotions-, and the physical symptoms. This is usually experienced as a moment of enhanced awareness and clarity, even relief, because they can see a light of hope for their state of stagnation and pain. Stern (2004) terms this "present moment." They calm them down, their fear of bodily symptoms diminishes, and even if they continue to suffer from them, they do not react with panic, they do not consider them a threat but part of a natural, adaptive response of their body to a stressful situation. The vicious circle (fear—more neurohumoral activation—more symptoms) is interrupted; and catastrophic anticipations and ruminations gradually diminish. Their own resources are activated, and they become more aware of the participation they may have in their own healing.

Conclusions

Not all interviews are as linear as described, and each patient makes his/her own way as far as he/she is capable of. Even though, my 10-year experience of adapting Open Dialogue dialogism to my professional practice has confirmed that it is far superior to the psychodidactic one of cognitivism, which I have practiced before.

In the follow-up meeting most of the patients reported feeling better, calmer, and more hopeful. Also having been able to talk with their families and taking fewer medications for their problems. Some continue the conversation of the first consultation, and those who have finally consulted a psychologist have tripled in 5 years.

Regarding consultation time, it is difficult to dedicate 40–60 min to all patients. But just as we devote more time to severe and complex patients with organic pathologies than to others, we should consider and treat these patients in the same way. For other patients with a clearer awareness of the relationship with emotional states, a shorter conversation is sometimes sufficient.

I believe that we should not wait for health systems to take the first step in the direction of change, but be the ones to initiate that, even with a small number of patients to gain confidence in the model and experience.

I am convinced that Seikkula's vision of dialogism is a useful and feasible option to apply in our medical reality. And that it can make an enormous contribution to generate a more humane, more integral, and consequently, more efficient medicine.

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The author confirms being the sole contributor of this work and has approved it for publication.

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The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Evaluating Open Dialogue in Italian mental health services: evidence from a multisite prospective cohort study

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Objective: This longitudinal study aimed to quantitatively document and evaluate the implementation and outcomes of the Open Dialogue (OD) approach within Italian Mental Health Departments (MHDs), focusing on the ratings of OD-network meetings by patients and their families and assessing the clinical outcomes over a span of 12 months.

Results: Over the course of the study, 58 patients participated in 517 OD-network meetings, demonstrating a high level of satisfaction with the care received, as evidenced by the Session Rating Scale (SRS) and Outcome Rating Scale (ORS). Clinically, significant improvements were observed in the Global Assessment of Functioning (GAF), Clinical Outcomes in Routine Evaluation (CORE-OM), and the Lubben Social Network Scale (LSNS), indicating enhanced psychological and social functioning. The SRS scores showed that satisfaction with the meetings increased over time, while the ORS indicated that both patients and their social networks perceived gradual improvements throughout the therapy.

Conclusion: The OD approach within Italian MHDs was successfully implemented and well-received by patients and their social networks, yielding significant clinical improvements. These findings suggest the feasibility and effectiveness of integrating the OD model into the Italian public mental health system, supporting its potential for broader application in diverse healthcare settings. The study highlights the importance of continuous engagement and evaluation to maintain high standards of practice and suggests that OD can be a valuable addition to existing mental health care practices, promoting recovery through inclusive, dialogue-based interventions.

KEYWORDS

Open Dialogue, mental health, treatment outcomes, clinical outcomes, social networks, patient satisfaction

1 Introduction

1.1 Background and principles of Open Dialogue

The public mental health service in the Finnish province of Western Lapland currently operates according to the principles of Open Dialogue (OD), an approach to mental health that emerged in the same area in the 1980s. Two main ideas are based on OD: one refers to the therapeutic approach that is adopted during meetings with patients, and the other applies to how the mental health service is organized (Seikkula et al., 2001).

According to the OD approach, treatment is provided in the form of "network meetings," which include the participation of the patients, their family, their social network, and the crisis intervention team. Over the years, seven principles have been formalized to describe the characteristics of OD, with "tolerance of uncertainty" and "dialogism" being the two main guidelines at the base of the conversations that take place during the meetings (Seikkula et al., 2001). The first organizational principle refers to arranging the initial meeting 24 h after the first contact. The second organizational principle explains that the client's social network, including family members and other key persons, must be invited to the first meeting with the client. "Flexibility and mobility," the third organizational principle, deals with the idea that treatment should adapt to the client's needs, and the meetings should be arranged as much as possible at their home. According to the fourth organizational principle, the first staff member who encounters a request for mental health support is responsible for organizing the initial meeting. Finally, the last organizational principle, "psychological continuity," refers to the idea that the staff members of the team become accountable for the treatment until its completion. Moreover, the different therapies that may be required (e.g., family, individual, group, occupational, and pharmacological) should be integrated into a continuous process.

These seven basic principles have been expanded and refined into 12 fidelity criteria that support the implementation of Dialogic Practice at the global level (Olson et al., 2014). The fidelity criteria were defined as follows: (1) two (or more) therapists in the team meeting; (2) participation of family and network; (3) use of open-ended questions; (4) respond to clients' utterances; (5) emphasize the present moment; (6) eliciting multiple viewpoints; (7) use of a relational focus in the dialogue; (8) responding to problem discourse or behavior in a matter-of-fact style and attentive to meanings; (9) emphasizing the clients' own words and stories, not symptoms; (10) conversation among professionals (reflections) in the treatment meetings; (11) being transparent; and (12) tolerating uncertainty.

These therapeutic elements are grounded in several key theoretical assumptions, which Seikkula and Olson (2003) define as the poetics of Open Dialogue.

At the core of the principle of tolerance of uncertainty is the idea that each crisis is unique and that maintaining a high tolerance for uncertainty in therapeutic work is essential. This principle encourages therapists to remain calm and avoid premature conclusions, even in high-risk and emotionally intense situations. By embracing the unknown and its inherent possibilities, new meanings can naturally emerge through collective dialogue. This approach is closely tied to the importance of establishing a trustworthy therapeutic context, where safety and trust are paramount for both therapists and families.

Dialogism, rooted in Bakhtin's concept of dialogue (Bakhtin, 1984), views dialogue as both a process and an objective of therapy. During a crisis, it is essential to create an environment where all voices and perspectives are expressed and taken seriously. This approach transforms the experience of crisis from an isolating condition into a shared communicative process. The collaborative nature of this dialogue, supported by the presence of multiple facilitators, ensures that everyone feels heard and respected, which is crucial for building mutual understanding and trust within the network.

Polyphony involves recognizing and integrating multiple voices and perspectives into the therapeutic process. Open Dialogue shifts the focus from trying to modify fixed relational structures to fostering a dynamic, co-evolving dialogue where all participants can express their views. Reflective practice (Andersen, 1991) is essential for recognizing and utilizing this polyphony, enriching the therapeutic dialogue and promoting a deeper understanding of the crisis.

In addition to the core principles of Open Dialogue, several other values are central to this approach, namely equality, democracy, respect, transparency, and process orientation (Putman, 2021).

Open Dialogue emphasizes treating all voices equally in network meetings, ensuring that professional opinions do not dominate. This democratic approach reflects the Finnish cultural ethic, fostering respect for diverse and even conflicting viewpoints. When decision-making proves challenging, inviting additional perspectives can enhance the dialogue and provide fresh momentum.

Maintaining transparency, professionals avoid discussing the network without its members present, thereby reinforcing respect and strengthening the therapeutic process. Reflections are openly shared during meetings, allowing team members to address difficult topics skillfully and respectfully. This practice enriches understanding and supports the network's ability to make sense of their experiences collectively.

The approach is inherently process-oriented rather than goal-oriented, emphasizing the experience of sustained participation in network meetings. Trusting the process involves the belief that ongoing engagement in these meetings will effectively address significant issues. This ongoing engagement gradually shifts communication from monologic to dialogic, fostering genuine dialogue, deeper understanding, and meaningful transformation in relationships and behaviors.

1.2 Research evidence and insights on Open Dialogue

Cohort studies investigating the OD approach in Western Lapland have demonstrated positive outcomes for almost 30 years (Seikkula et al., 2006, 2011; Bergström et al., 2018, 2022). The first cornerstone studies explored the effectiveness of OD within the Finnish national multicenter Integrated Treatment of Acute Psychosis (API) project (April 1992–December 1993) and its continuation, the Open Dialogue Approach in Acute Psychosis (ODAP) project (1994–1997; Seikkula et al., 2003, 2006). A third study, conducted between 2003 and 2005, examined whether previous results remained stable over the years (Seikkula et al., 2011).

Researchers have evaluated several outcomes in the treatment of first-episode psychosis, including psychotic symptoms, use of neuroleptic medications, number of relapses, employment status, and

granting of disability allowance (Seikkula et al., 2011). They observed that in all three cohorts, more than 80% of patients had no residual symptoms at the two-year follow-up. Moreover, they found that only 16% of the patients in the ODAP2003-2005 group were on disability allowance, while 84% had returned to full employment or studies after 2 years of treatment.

A few years later, Bergström et al. (2018) compared a group of OD patients from the Western Lapland research cohort with a control group of patients who experienced first-episode psychosis and were referred to the Finnish public specialized healthcare system. The study confirmed that positive outcomes, such as the reduced need for psychiatric treatment or hospitalization and disability allowances, were maintained for over 19 years. Similarly, an evaluation of the treatment outcomes of a group of adolescents has recently highlighted how patients in the OD group were less likely to receive treatment or disability allowance at the 10-year follow-up (Bergström et al., 2022).

Although OD have been implemented in more than 20 countries (Pocobello et al., 2023), its transferability and positive outcomes have been demonstrated in very few contexts.

Gordon et al. (2016) explored the adaptation of Open Dialogue (OD) in the United States through the implementation of a program named the Collaborative Pathway (CP). The feasibility and effectiveness of CP were assessed using qualitative interviews, surveys, and clinical records. Despite the study's limitations, such as a small sample size of only 14 patients, it yielded promising results concerning the transferability of the approach. Notably, network meetings generated high satisfaction levels among patients, their families, and staff members. Clinical outcomes, assessed through both surveys and clinical records, showed improvements in symptoms, functioning, and the need for care. Remarkably, more than half of the participants (nine out of 14) had returned to work or educational pursuits after 1 year of treatment.

Kinane et al. (2022) investigated the implementation and outcomes of a variation of Open Dialogue that incorporated peer support (POD), offered by a standalone team within the United Kingdom's National Health System. This study employed a before-and-after design involving 50 service users and 25 carers over 6 months. Researchers assessed health and social function through both user self-reports and clinician-rated scales, as well as service experience, well-being, and carer support. All measures showed improvements from baseline scores at the three-and six-month marks, with an observed increase in employment or educational engagement.

Two other studies are currently underway to evaluate the efficacy of the OD approach. The first, conducted in the United Kingdom, is part of a comprehensive research initiative called ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness). This initiative includes the first randomized controlled trial of OD, with results expected this year (Pilling et al., 2022). Internationally, the HOPEnDialogue project[1] seeks to synergize various global research efforts within the ODDESSI framework. Launched in June 2022, the project's pilot phase is exploring the feasibility of conducting a multinational study and is assessing whether clinical outcomes associated with OD—such as time to relapse, quality of life, and social network dimensions—align with those observed in the ODDESSI trial (Pocobello, 2021).

Regarding qualitative studies, they have shown that clients and family members tend to value several dimensions of the OD approach, including network involvement, the shared decision-making process, and the sense of being heard (Tribe et al., 2019; Florence et al., 2021; Gidugu et al., 2021; Buus and McCloughen, 2022). Similar experiences have also been observed in the long term, as shown in a study of service users from the original Western Lapland research cohort, who were interviewed 10–23 years after their first OD treatment (Bergström et al., 2022). Participants indicated that they appreciated attending network meetings, the interest shown by other people, and the opportunity to discuss their experiences openly and without feeling judged. On the other hand, mixed feelings were reported about some features of the OD approach, such as the immediate response (i.e., staff arriving suddenly at the client's home), teamwork (i.e., too many people attending meetings), hospitalization, and medication (Bergström et al., 2022).

In different implementation contexts, clinicians' experiences of OD have been associated with both opportunities and challenges (Florence et al., 2020; Dawson et al., 2021; Schubert et al., 2021; Jacobsen et al., 2023; Skourteli et al., 2023). Professionals participating in network meetings reported positive feelings such as a sense of liberation, collaboration, humanity, authenticity, and identity change (Florence et al., 2020; Dawson et al., 2021; Schubert et al., 2021; Jacobsen et al., 2023). Difficulties included, for example, that some practitioners felt burdened with responsibility, especially when unit managers were not supportive and engaged in the development of the approach (Jacobsen et al., 2023). Others found it difficult to link theory to practice, particularly in relation to transparency and reflective practice, and to manage uncertainty by giving up the need for control (Skourteli et al., 2023). Psychiatrists reported discomfort in dealing with situations of perceived high risk, describing vulnerability as "the greatest strength and the greatest challenge" (Schubert et al., 2021). Further research is needed to describe these barriers in different contexts and to help overcome them as the approach is implemented in clinical practice.

1.3 Open Dialogue in the Italian context

The research described in this paper was partially conducted under a project funded by the Italian Ministry of Health (Program CCM 2014), aimed at evaluating the transferability of the OD approach within the Italian National Health Service, which manages mental health care at the community level through Mental Health Departments (MHDs). Each MHD comprises all services and facilities devoted to mental health care, assistance, and prevention for users within a defined catchment area (Lora, 2009). MHDs may include Community Mental Health Centers (CMHCs; Centri di Salute Mentale), Day Care Facilities (DCF; Centri Diurni), General Hospital Psychiatric Units (GHPUs), and Residential Facilities (RFs).

The Open Dialogue (OD) project, initiated in February 2015, involved eight Mental Health Departments (MHDs) across six Italian cities—Catania, Modena, Rome, Savona, Trieste, and Turin—serving a population of 4 million inhabitants. Importantly, OD was not implemented across entire departments but was selectively applied in

1 https://www.hopendialogue.net/

specific areas, chosen based on team size and the organizational structure of each department.

The participating centers were invited by the coordination unit to join the project based on their interest and curiosity in learning about the Open Dialogue approach, as well as their expertise in similar collaborative approaches. Many professionals within these centers were already in contact with each other, sharing a common interest in recovery-based services, voice hearers' groups, democratic communities, and multi-family groups. Each department then selected candidates for training from those who volunteered. The entire process was based on motivated, committed, and voluntary participation at all levels.

Initially conceived as a two-year project, this initiative comprised 3 months of training followed by a year-long outcome study. It soon became apparent that a minimum of 1 year was essential to provide comprehensive foundational training in OD. This necessary extension delayed the initiation of the outcome study. Despite a brief extension granted toward the funding period's conclusion, the outcome study began with limited time remaining and proceeded without additional financial support. Subsequently, one department ceased participation following the formal conclusion of the project and did not continue into the outcome study phase.

The Italian OD project encompassed training and supervision for mental health professionals and explored the transferability of the approach through a structured research program. The Local Health Authority of Turin coordinated the project, while the National Research Council (CNR) oversaw the evaluation process. The program was divided into several phases: preliminary assessment, training, and an outcome study, each linked to a specific research focus.

In the preliminary assessment phase, the CNR unit conducted detailed evaluations through interviews with directors of the MHDs and questionnaires distributed to health professionals. This phase aimed to gauge the compatibility of the OD practices with the values and needs of both professionals and their organizations, identifying potential barriers and formulating strategies for implementation.

The training program engaged 80 mental health professionals, including psychiatrists, nurses, psychotherapists, social workers, and one expert by experience, who were organized into two classes. Initially, participants completed sessions on family therapy led by Italian psychotherapists. This was followed by 20 days of intensive OD training delivered by Finnish trainers. Supervision, a crucial aspect of the training, extended slightly beyond the planned year. The training phase was closely monitored through participatory observation by the evaluation unit.

To evaluate the adherence of professionals to OD principles during network meetings, each team submitted two video recordings at the training's conclusion. These recordings were analyzed using the Dialogic Practice Adherence Scale (Olson et al., 2014) by independent raters. The analysis confirmed sufficient adherence to OD practices (Ciliberto et al., 2017; Pocobello and el Sehity, 2017; Pocobello, 2021), which was vital for ensuring the professionals' practices met the rigorous standards required for faithful implementation of the OD approach. Only after achieving satisfactory fidelity and adherence scores did we move to the next phase.

The start date of the outcome study varied among the different MHDs in relation to the timing of approval from the local ethical committees; however, in all departments, the research concluded before November 2018. This final phase applied the skills and principles from the training in practical settings to evaluate the clinical outcomes and overall effectiveness of the OD approach in the Italian context.

Results from all phases were systematically reviewed in project coordination meetings, which facilitated informed decisions and adjustments throughout the implementation process. This structured approach ensured that each phase built upon the insights gained from the previous, enhancing the integrity and impact of the research presented in this article.

1.4 Aims

This study aims to quantitatively document both the implementation and the outcomes of the OD approach within Italian MHDs. The objectives include:

- Evaluating how patients and their families perceive OD network meetings.
- Analyzing the clinical outcomes for patients over a 12-month period.
- Assessing perceived changes in the social networks.

2 Methods

2.1 Study design

The study is a 12-month multisite prospective cohort study. Patients aged 18–64 years were included. Measurements were taken at baseline (t1), after 6 months (t2), and after 12 months (t3). Outcome variables are the Global Assessment of Functioning (GAF), Clinical Outcomes in Routine Evaluation—Outcome Measure (CORE-OM), and the Lubben Social Network Scale (LSNS-6). OD-Sessions were rated via two scales: Session Rating Scale (SRS) and Outcomes Rating Scale (ORS).

2.2 Sampling and recruitment process

For 1 month, the teams practiced OD to treat all individuals aged 18–64 who were seeking help for the first time in the designated area, continuing until their capacity to manage additional new requests according to OD principles was reached (Olson et al., 2014). No distinctions were made based on diagnosis, and all types of initial crises and requests for help were addressed using OD.

2.3 Data collection procedures

Immediately upon the initial call for help, patients were contacted within 24 h for treatment at their preferred location. A team committed to ensuring continuity of care throughout the treatment duration was assigned. At the first or second meeting with the patient (t0 = baseline), the opportunity to participate in the research was presented, and informed consent was obtained.

Following consent, data collection began, which included socio-demographic details and clinical diagnostics according to ICD-10. The scales utilized for further assessments were the CORE-OM (Evans et al., 2002) for monitoring routine clinical outcomes, the GAF (Endicott et al., 1976) to evaluate overall functioning, and the LSNS-6 (Lubben et al., 2006) to measure the size of the patient's social network. These measures were taken at baseline and subsequently at 6 and 12 months to track the effectiveness of the clinical interventions.

For process documentation and evaluation, the Session Rating Scale (Duncan et al., 2003) was used after each meeting to gauge satisfaction with the care received by patients and their networks. Additionally, the Outcome Rating Scale (Miller et al., 2003) was administered every 2 weeks during scheduled meetings to continuously assess perceived outcomes.

2.4 Measurement tools and variables

2.4.1 Instruments for process evaluation

2.4.1.1 SRS

The Session Rating Scale (Duncan et al., 2003) is a client-reported outcome measure designed to evaluate the therapeutic alliance and session satisfaction in individual network meetings. It consists of a single item in which clients rate their overall experience of the session on a 0–10 scale. SRS allows clients to provide feedback on various aspects of the therapeutic process, including the quality of the therapeutic relationship, the perceived helpfulness of the session, and their level of engagement. It serves as a simple yet valuable tool for therapists to monitor and assess a client's experience, identify areas of improvement, and enhance the effectiveness of therapy by incorporating client feedback into the treatment process.

2.4.1.2 ORS

The Outcome Rating Scale (Miller et al., 2003) is a client-reported outcome measure used to assess the overall outcome and progress of therapy. It consists of four items that cover different domains of well-being: individual well-being, interpersonal relationships, social roles, and overall satisfaction with life. Clients rated their level of functioning in each domain on a 0–10 scale, providing a snapshot of their subjective experience and perceived improvement over time. The ORS is a valuable tool for monitoring treatment progress, evaluating therapeutic outcomes, and facilitating client-centered discussions regarding goals and areas of focus in therapy. This enables therapists to incorporate client feedback, track changes, and tailor interventions to address specific needs and concerns.

2.4.2 Instruments for the evaluation of outcome

2.4.2.1 GAF

The Global Assessment of Functioning (Endicott et al., 1976) scale is a clinician-rated measure that assesses an individual's overall level of psychological, social, and occupational functioning. It is commonly used in mental health settings to evaluate functional impairment and overall wellbeing. The GAF scale rates individuals on a continuum from 0 to 100, with lower scores indicating greater impairment, and higher scores indicating better functioning. It considers various factors, such as symptoms, functioning in daily life, social relationships, and work/school performance. The GAF scale provides a summary score that helps clinicians gauge the severity of mental health conditions, track changes over time, and inform treatment plans and interventions. The scale is widely used in routine clinical settings (Aas, 2010).

2.4.2.2 CORE-OM

The Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002) is a self-report questionnaire designed to assess psychological distress and well-being among individuals receiving mental health services. It consists of 34 items covering four domains: subjective well-being, symptoms/problems, functioning, and risk/harm. Respondents rated each item on a five-point Likert scale indicating the extent to which they experienced specific difficulties or distress over the past week. The CORE-OM scale provides a comprehensive assessment of a person's emotional and psychological states, allowing clinicians and researchers to monitor treatment progress, evaluate outcomes, and identify areas of concern in mental health interventions. The scale had a high level of internal consistency across the three different time points (t0; t1; t2) as determined by Cronbach's alphas of 0.937; 0.951; 0.949, respectively.

2.4.2.3 LSNS-6

The Lubben Social Network Scale-6 (Lubben et al., 2006) is a brief self-report questionnaire used to assess social isolation and support among older adults. It consists of six items that capture both the structural aspects of social networks (e.g., frequency of contact and number of close relationships) and the functional aspects of social support (e.g., availability of emotional support and practical assistance). The LSNS-6 scale provides a quick and reliable measure of an individual's social connectedness and can help identify older adults who may be at risk of social isolation or lack sufficient social support. The LSNS-6 was employed in this study to assess social networks and social support, and to screen for the social isolation of patients. The scale is constructed from two sets of three questions: one forming the family subscale and the other forming the friends' subscale. The scale had a high level of internal consistency across the three time points (t0; t1; t2) as determined by Cronbach's alpha of 0.84; 0.80; 0.84, respectively, similar to the consistency described by Lubben et al. (2006) of 0.83.

2.5 Sample

During the one-month recruitment phase, 125 individuals reached out for assistance within the designated catchment areas. Of these, 21 were deemed ineligible for the study for the following reasons: 9 due to their sole request of medical certifications, 7 because they were not first-time patients, 3 fell outside the age criteria of the study, and 2 due to their sole requested of a physician. This resulted in 104 potentially eligible participants of whom 32 chose not to participate; their reasons included reluctance of their social network to participate (14 cases), refusal to be part of a study (12 cases), and discomfort speaking in front of multiple people (6 cases). Thus, 72 participants were eligible yielding a recruitment rate of 69.2%. Due to the withdrawal of one mental health department after the first moth of the study the data of 8 participants were lost; 6 more participants disengaged after the first month of the study, bringing about an attrition rate of 19.4%. Of the

remaining 58 participants, data were missing for 11 users at month 6 and for 11 users at month 12. In total, 40 users had complete data at all three time points. Details of the participant characteristics are summarized in Table 1.

2.6 Data analysis strategies

Firstly, descriptive statistics are provided for sample characteristics. An analysis of variance (ANOVA) was conducted to examine the age differences of the session participants based on their roles and gender.

We carried out an analysis to examine patterns of missing values in our process (SRS and ORS) and outcome variables (GAF, CORE-OM, LSNS-6) to determine if the data were missing at random. This step was crucial for validating the assumptions of our mixed model analysis. The results confirmed that incomplete data were indeed distributed at random. We then employed a linear mixed-effects model to analyze the longitudinal data collected across multiple time points. This statistical approach was chosen due to its ability to reduce the loss of information about patients of which data of only two timepoints were available (Heck et al., 2022). Linear mixed models use maximum likelihood estimation, which allows them to incorporate all available information even when there are missing data points, which is in contrast to repeated-measures ANOVA, which typically removes incomplete cases (de Melo et al., 2022). Each subject's repeated observations were modeled with fixed effects for time, capturing the systematic changes in the dependent variable, while random intercepts were included to account for individual differences at baseline. The models were fitted using Restricted Maximum Likelihood (REML) estimation to provide unbiased estimates of the variance components under the assumption that the fixed effects are correctly specified. This modeling strategy allowed us to directly assess the impact of time on the outcome measure while controlling for within-subject correlation and between-subject heterogeneity. Model fit was evaluated using the Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC), and the proportion of variance explained by the models was quantified using marginal and conditional R-squared values. Residual diagnostics were performed to assess assumptions of normality and homoscedasticity, ensuring the robustness of our inferences.

Linear mixed models were calculated using Jamovi (The Jamovi Project, 2022) module for General analyses for linear models (Gallucci, 2019).

3 Results

3.1 Descriptives of OD-network meetings

517 OD network meetings with 58 patients were reported during the 12 months duration of the study. The average number of

TABLE 1 Characteristics of study participants at baseline, 6 months, and 12 months.

Characteristics	Baseline (*N* = 58)	Month 6 (*N* = 47*)	Month 12 (*N* = 47*)
Sociodemographic			
Men, *n* (%)	21 (36.2)	15 (31.9)	17 (36.2)
Women, *n* (%)	37 (63.8)	32 (68.1)	30 (63.8)
Age at baseline, *M (SD)*	36.4 (13.9)	37.9 (14.4)	36.8 (14.3)
Studies at baseline (missing, n = 1)			
Studies, *n* (%)	12 (20.7)	9 (19.1)	10 (21.3)
No Studies, *n* (%)	45 (77.6)	38 (80.9)	37 (78.7)
Occupational Status at baseline (missing, n = 2)			
Work, *n* (%)	31 (53.4)	28 (59.6)	27 (57.4)
No Work, *n* (%)	25 (43.1)	18 (38.3)	20 (42.6)
Relationship status at baseline			
Married/Cohabits, *n* (%)	14 (25.0)	14 (29.8)	12 (25.5)
Divorced/Separated, *n* (%)	7 (12.5)	4 (8.5)	4 (8.5)
Single/Widowed, *n* (%)	37 (62.5)	29 (61.7)	31 (66.0)
Clinical characteristics			
ICD 10 Diagnostic (missing, n = 12)			
F10–F19 Mental and behavioral disorders due to psychoactive substance use, *n* (%)	1 (2.2)	0 (0.0)	0 (0.0)
F20–F29 Schizophrenia, schizotypal and delusional disorders, *n* (%)	8 (19.6)	8 (21.6)	8 (21.6)
F30–F39 Mood [affective] disorders, *n* (%)	10 (21.7)	6 (16.2)	7 (18.9)
F40–F48 Neurotic, stress-related and somatoform disorders, *n* (%)	20 (43.5)	17 (45.9)	17 (45.9)
F50–F59 Behavioral syndromes associated with physiological disturbances and physical factors, *n* (%)	1 (2.2)	1 (2.7)	1 (2.7)
F60–F69 Disorders of adult personality and behavior, *n* (%)	4 (6.9)	3 (8.1)	4 (10.8)
F70–F79 Mental retardation, *n* (%)	2 (3.4)	2 (5.4)	0 (0.0)

*The participants at time points month 6 and month 12 are not identical since of 18 participants only 2 two time-point measures were available.

OD-network meetings per patient treated was 8.08 ($SD = 5.74$; $Md = 6$; $Min = 1$; $Max = 25$) and an average number of social network members participating in OD-network meetings was 0.96 ($SD = 0.90$; $Md = 1$; $Min = 0$; $Max = 7$). The number of social network members participating in OD-network meetings was 17% higher for male patients than for female patients ($B = 0.167$; $SE = 0.06$; $p = 0.006$).

Of the 517 OD-network meetings 158 meetings (30.6%) included only the patient, 217 (42%) meetings included one social network member, 98 meetings (19%) included two members, 30 (5.5%) three members and 14 (2.7%) meetings included four or more members (max. 8).

28% of the network meetings were rated by patients' mothers, 18% fathers, 14% partners, 10% sisters, 8% brothers, 2% daughters and 2% others. Consequently, the age structure between genders varied systematically based on their role in OD-session as patients or social network members. The mean age of social network members was 46.4 years ($SD = 18.0$; min. 15.0 to max. 82.0); the mean age of patients was 36.4 years ($SD = 13.4$), ranging from 18.0 to 61.0 years (see Table 1). The results of a one-way ANOVA revealed a significant main effect of the role of participants on age [$F(1, 123) = 11.62$, $p < 0.001$], indicating that social network members tended to be older than patients. However, there was no significant main effect of gender of session-participants on age [$F(1, 123) = 0.08$, $p = 0.780$]. Furthermore, *post hoc* comparisons revealed that there were no significant age differences between male patients and female patients ($p = 0.357$; see Figure 1).

3.1.1 Session rating scale of OD-network meetings

1,080 session rating scales (SRS) were completed to assess 517 OD-network meetings. 517 SRS were completed by patients ($M = 34.9$; $SD = 7.17$; $Md = 38.8$;) and 563 SRS by members of their social network ($M = 34.4$; $SD = 6.79$; $Md = 36$). A one-sample t-test revealed that these SRS scores were significantly above the mean global SRS-scores of 32.4 ($SD = 5.9$; $t = 7.905$, $p < 0.001$) reported in the cross-cultural examination of the scale by Hafkenscheid et al. (2010). The data were skewed to the higher endo of the scale indicating the prevalence of positive ratings of the OD-network meetings.

To explore patterns in the appreciation of OD-network meetings throughout the therapeutic journey, the rank-order of OD-network meetings was standardized: (1st, 2nd, 3rd …) divided by the total number of OD-network meetings recorded so that the last OD-session was designated with the reference value 1 and all earlier OD-network meetings were allocated a "temporal order" score approximating 0; (2) the role of session participants (patient vs. social network member). The linear mixed model analysis examined the association between the SRS and the following predictors: (1) Role of session participant, (2) standardized rank-order of OD-network meetings (ranging from <0 to 1, where 1 represents the last session), and (3) the interaction between Role of session participant and standardized rank-order of OD-session. The model included random intercepts for social network and individual level. The fixed effects omnibus tests indicated a marginally significant effect for role of session participant ($F = 3.38$, $p = 0.066$) and a significant effect for Order of OD-session ($F = 4.07$, $p = 0.044$), suggesting that these variables were associated with the SRS scores. There was no statistically significant interaction effect between role of session participant (patient vs. social network members) and temporal rank order of OD-session ($F = 1.95$, $p = 0.163$).

The fixed effects parameter estimates showed that there was no significant difference in SRS-scores between patients and their social network members ($B = -0.693$, $SE = 0.377$, $p = 0.066$). Overall, the interaction between role of session participants (patient or social network member) and the rank of OD-session did not significantly influence SRS scores ($B = 1.727$, $SE = 1.235$, $p = 0.163$). Patients, however, rated later OD-session in the therapy significantly more positively than their early OD-network meetings ($B = 1.347$, $SE = 0.668$, $p = 0.044$; see Figure 2).

3.1.2 Outcome rating scale of OD-network meetings

A mixed model analysis was employed to explored the relationship between the Outcome Rating Scale (ORS) and the following predictors: Role of session participant (Patient or Social network

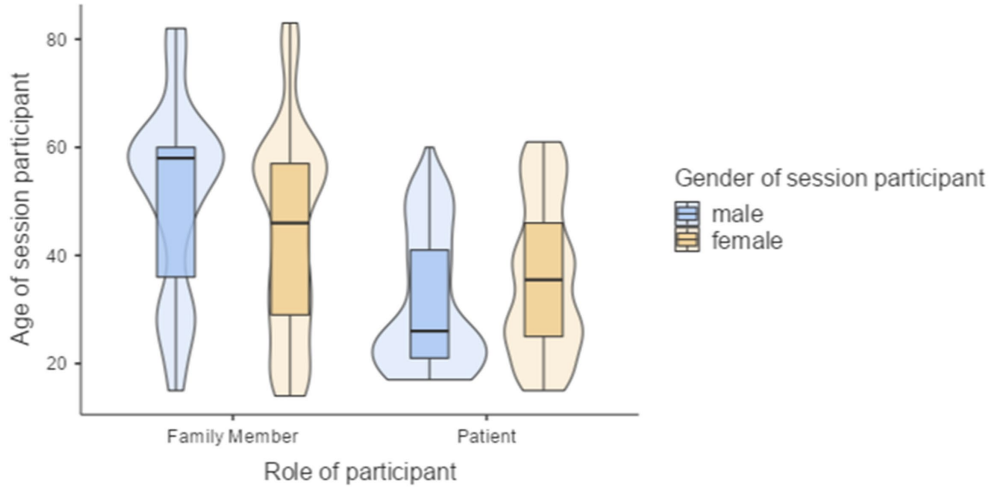

FIGURE 1
Age structure and gender of OD-network meeting participants based on their role as social network members and patients.

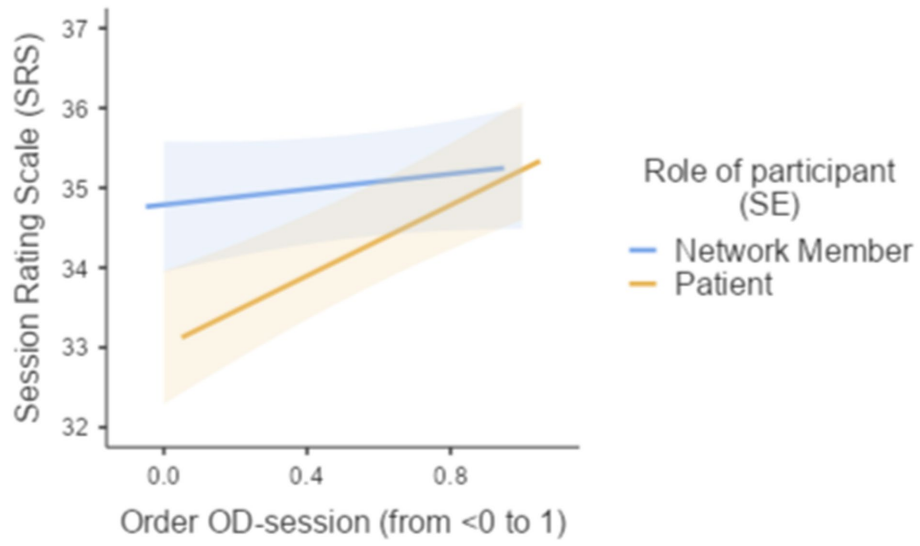

FIGURE 2
Effects plot of SRS and the order of OD-network meetings during the OD-therapy.

members), standardized rank-order of OD-network meetings, and the interaction between role of session participant and standardized rank-order of OD-session. The model included random intercepts for Social network and individual level ratings ("Super ID"). The fixed effects parameter estimates indicated that patients rated the outcome of OD-network meetings significantly lower than their social network members ($B = -4.73$, $SE = 1.26$, $p < 0.001$), while the Order of OD-session was positively associated with ORS scores ($B = 6.40$, $SE = 1.01$, $p < 0.001$). The interaction between Role of session participant and Order of OD-session did not have a significant effect on ORS scores ($B = 1.60$, $SE = 1.99$, $p = 0.421$; see Figure 3).

In conclusion, the multilevel mixed model analysis showed that the role of session participant and order of OD-session were significant predictors of ORS scores. Patients rated the outcome of OD-network meetings lower compared to social network members, and the outcome of OD-session was rated higher over the course of the OD-therapy.

3.2 Outcomes evaluation

Table 2 presents longitudinal data on clinical outcomes measured across three time points: baseline, 6 months, and 12 months. The outcomes include the Global Assessment of Functioning (GAF), various dimensions of the Clinical Outcomes in Routine Evaluation—Outcome Measure (CORE-OM), and scores from the Lubben Social Network Scale (LSNS). This table provides a comprehensive overview of changes in mental health and social support over the course of the study, reflecting both individual and aggregate trends in the participant sample.

3.2.1 GAF scores: a linear mixed model analysis

A linear mixed-effects model was fitted using Restricted Maximum Likelihood (REML) to investigate the influence of time on the General Assessment of Functioning (GAF) scores, accounting for random intercepts for individual subjects (RID). Tests for normality of residuals indicated that the residuals were approximately normally distributed, as shown by the Kolmogorov–Smirnov test ($D = 0.0601$, $p = 0.650$) and the Shapiro–Wilk test ($W = 0.9853$, $p = 0.112$). The model used the formula GAF~1 + time + (1 | RID). The analysis yielded an Akaike Information Criterion (AIC) of 1166.373 and a Bayesian Information Criterion (BIC) of 1174.169. The model's marginal R-squared was 0.155, suggesting that fixed effects alone accounted for approximately 15.5% of the variance in GAF scores, while the conditional R-squared was 0.613, indicating that the total model, including random effects, explained 61.3% of the variance.

The model included random intercepts for RID, which demonstrated a standard deviation of 9.67, corresponding to a variance of 93.6. The intraclass correlation coefficient (ICC) was 0.542, indicating that approximately 54.2% of the variability in GAF scores was due to differences between subjects.

The effect of time on GAF was statistically significant, with an F-statistic of 56.7 ($df = 1, 101$, $p < 0.001$), indicating a substantial effect over time. Specifically, the GAF scores increased by 6.78 for each additional time unit ($SE = 0.901$, 95% CI [5.02, 8.55], $t(100.9) = 7.53$, $p < 0.001$; Figure 4).

3.2.2 CORE-OM

A linear mixed-effects model was applied to evaluate the influence of time on CORE-OM scores, accounting for random intercepts for individuals (RID). Tests for the normality of residuals indicated no violations of normality: Kolmogorov–Smirnov test ($D = 0.0532$, $p = 0.806$) and Shapiro–Wilk test ($W = 0.9861$, $p = 0.152$), suggesting that the assumption of normally distributed residuals holds for this model. The model was fitted using Restricted Maximum Likelihood (REML). The analysis resulted in an Akaike Information Criterion (AIC) of 287.5776 and a Bayesian Information Criterion (BIC) of 306.7380. The marginal R-squared was 0.0612, suggesting that fixed effects explained approximately 6.12% of the variance in CORE scores. The conditional R-squared was substantially higher at 0.5917, indicating that including random effects accounts for approximately 59.17% of the variance.

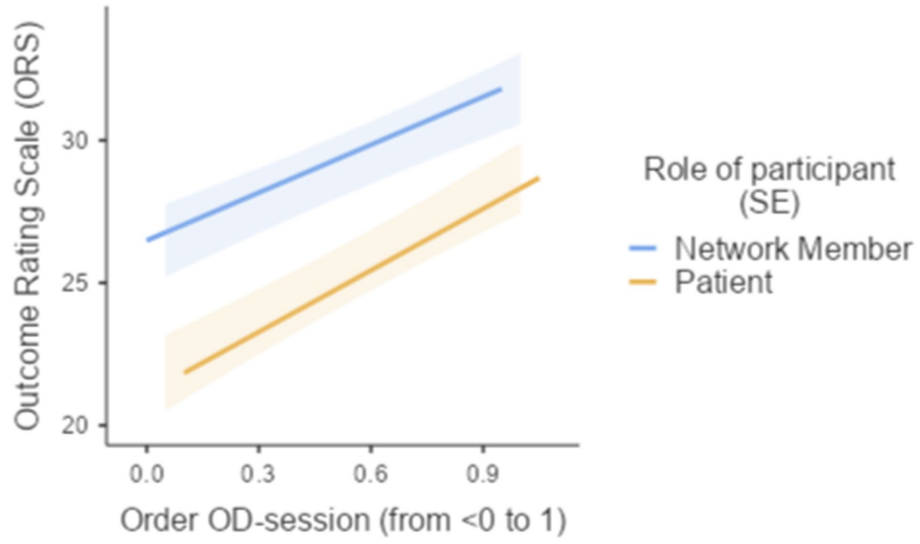

FIGURE 3
Effects plot of ORS and the order of OD-network meetings during the OD-therapy.

TABLE 2 Global assessment of functioning (GAF), CORE-OM, Lubben social network scale (LSNS).

Clinical outcomes	Baseline (*N* = 58)	Month 6 (*N* = 47)	Month 12 (*N* = 47)
Global Assessment of Functioning (GAF)			
M (SD); n(t)	63.3 (13.85); 56	70.81 (11.73); 47	77.4 (14.3); 47
CORE-OM (Evans et al., 2002)			
Well-being, *M (SD)*	2.42 (0.94)	1.71 (1.01)	1.77 (1.06)
Symptoms, *M (SD)*	2.09 (1.00)	1.43 (0.87)	1.50 (0.93)
Functioning, *M (SD)*	1.70 (0.75)	1.35 (0.71)	1.50 (0.77)
Risk, *M (SD)*	0.63 (0.74)	0.30 (0.53)	0.33 (0.53)
CORE-OM no R, *M (SD)*	1.97 (0.78)	1.43 (0.76)	1.54 (0.82)
CORE-OM, *M (SD); n*(t)	1.73 (0.73); 56	1.23 (0.70); 47	1.33 (0.74); 42
Lubben social network scale (LSNS-6)			
Family Subscale, *M (SD)*	2.24 (1.03)	2.49 (1.05)	2.33 (0.95)
Friends Subscale, *M (SD)*	2.27 (1.10)	2.53 (1.20)	2.49 (1.17)
LSNS-6, *M (SD); n*(t)	2.26 (0.95); 57	2.51 (0.93); 48	2.41 (0.94); 42

The fixed effect of time on CORE scores was significant, $F(1, 94.1) = 19.8$, $p < 0.001$. The model estimated a significant decrease in CORE scores over time, with each unit increase in time associated with a decrease of 0.228 in CORE scores (SE = 0.0511, 95% CI [−0.328, −0.127], $t(94.1) = -4.45$, $p < 0.001$; Figure 5).

3.2.3 Lubben Social Network Scale

A linear mixed-effects model was conducted to assess the effect of time on Lubben Social Network Scale (LSNS) scores, accounting for random intercepts associated with individual subjects (RID). Tests for the normality of residuals revealed a deviation from normality with the Shapiro–Wilk test ($W = 0.9681$, $p = 0.002$), suggesting potential issues with the normal distribution assumption of the residuals, although the Kolmogorov–Smirnov test did not show significant results ($D = 0.0952$, $p = 0.139$). The model was fitted using Restricted Maximum Likelihood (REML). It provided an Akaike Information Criterion (AIC) of 345.2901 and a Bayesian Information Criterion (BIC) of 363.7063. The analysis showed a marginal R-squared of 0.0101, indicating that the fixed effects explained approximately 1.01% of the variance in LSNS scores. The conditional R-squared was significantly higher at 0.6683, suggesting that including random effects accounts for about 66.83% of the variance.

The random effects indicated a standard deviation of 0.764 for the intercepts across RID, corresponding to a variance of 0.584. The intraclass correlation coefficient (ICC) was 0.665, reflecting a substantial portion of the variability in LSNS scores attributable to differences among subjects.

The fixed effect of time was statistically significant, $F(1, 93.4) = 4.06$, $p = 0.047$. The parameter estimate for time indicated a positive effect, with each unit increase in time associated with an average increase of 0.116 in LSNS scores (SE = 0.0574, 95% CI [0.00321, 0.228], $t(93.4) = 2.02$, $p = 0.047$; Figure 6).

Table 3 consolidates the key model parameters and fit statistics derived from the linear mixed models for each of the three outcome variables—Global Assessment of Functioning (GAF), Clinical Outcomes in Routine Evaluation (CORE-OM), and the Lubben Social Network Scale (LSNS). This table provides a summary of the estimates, standard errors, degrees of freedom, t-values, *p*-values, and confidence intervals for both intercepts and time effects across the models. Additionally, the table displays the marginal and conditional R^2 values, which help quantify the proportion of variance explained by the fixed effects alone and by the entire model respectively, offering insights into the effectiveness of the interventions over time.

4 Discussion

The primary objectives of this research were to document and describe the implementation of the OD-approach by the means of

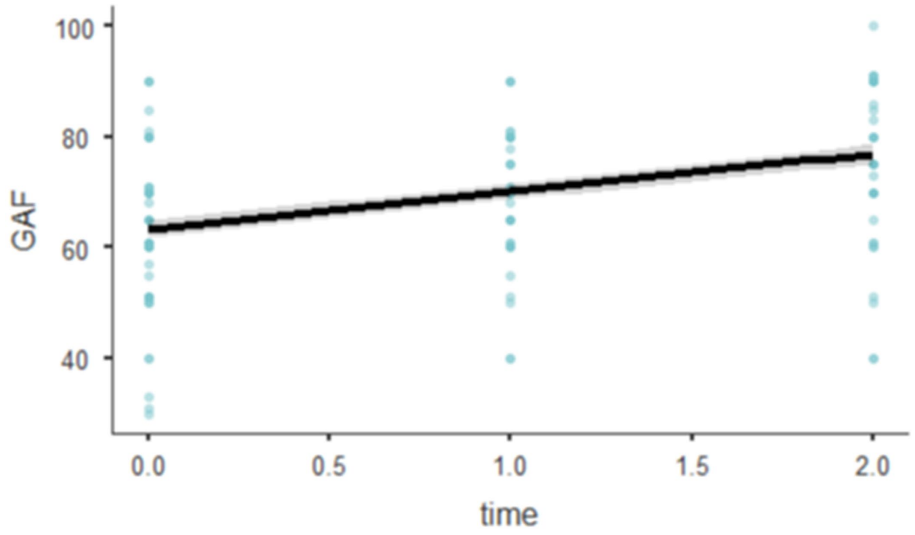

FIGURE 4
Effects plots of GAF.

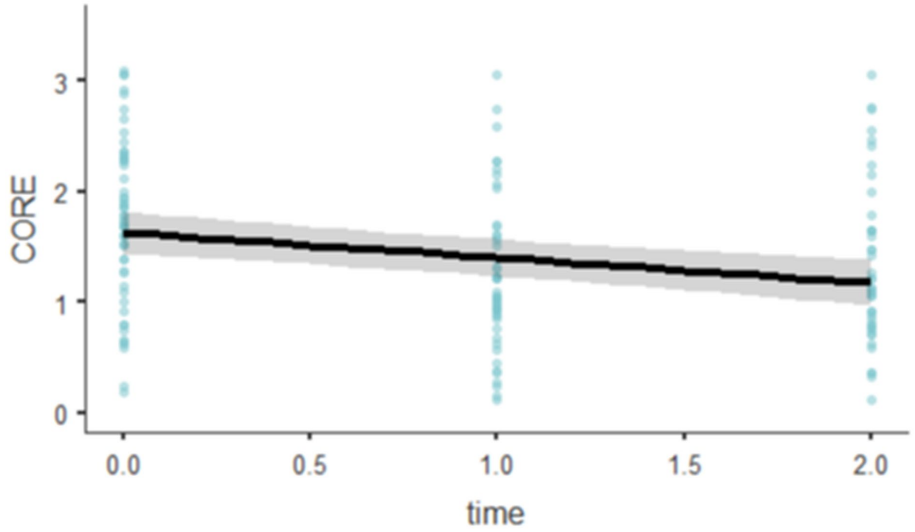

FIGURE 5
Effect plots of CORE-OM.

patients' and their social network members' rating of OD-network meetings and to assess the clinical outcomes for patients and families receiving treatment based on the OD approach in Italian MHDs over a span of 12 months.

517 OD network meetings involving 58 patients and their social network took place across a span of 12 months. Within these 12 months patients attended an average of eight OD network meetings, and each session saw participation from an average of one social network member, where male patients had a 17% higher number of social network participation in comparison to female patients.

The evaluation of OD-Network meetings using the Session Rating Scale (SRS) and Outcome Rating Scale (ORS) provided evidence of the positive reception (SRS) and perceived effectiveness (ORS) of the Open Dialogue approach. The SRS results indicated that both patients and their social network members consistently rated the sessions highly, with scores significantly above the cross-cultural mean documented cross-cultural examination of the scale by Hafkenscheid et al. (2010). This suggests a high level of satisfaction with the network meetings, reflecting strong therapeutic alliances and effective engagement of participants. Moreover, the linear mixed model analysis of SRS scores revealed that later sessions were rated more positively, indicating a growing appreciation for the meetings as therapy progressed. In contrast, the ORS assessments highlighted a divergence in perceptions of outcomes between patients and their social network members, with patients generally rating the outcomes lower than their social network members. However, there was a positive trend in ORS scores over time, suggesting that both patients and social network members perceived

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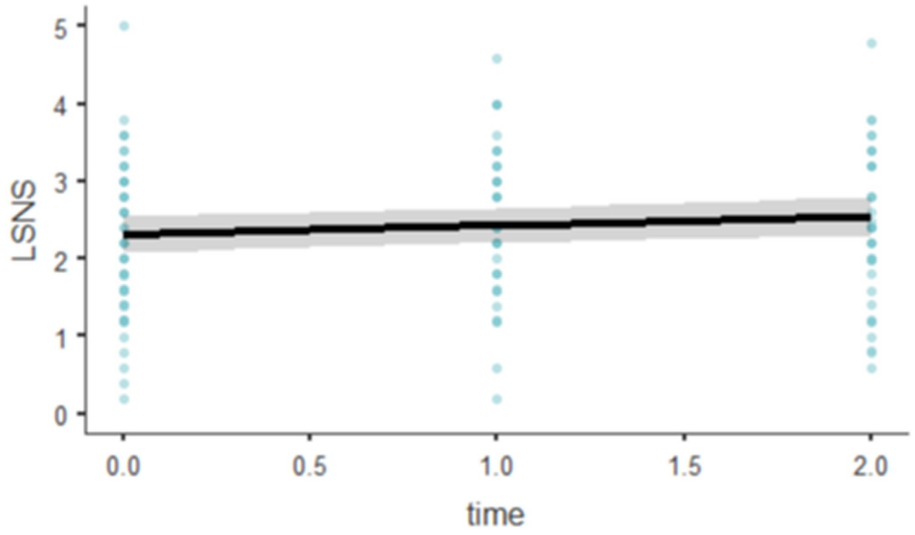

FIGURE 6
Effect plots of LSNS-6.

TABLE 3 Model parameters and fit statistics for linear mixed model of the three outcomes.

Outcome	Parameter	Estimate	SE df	Df	t	*p*-value	95% CIT	Marginal R2	Conditional R2
GAF	Intercept	69.81	1.489	58.7	46.90	<0.001	[66.89, 72.72]	0.155	0.613
	Time	6.78	0.901	100.9	7.53	<0.001	[5.02, 8.55]		
CORE-OM	Intercept	1.629	0.094	87.5	17.35	<0.001	[1.445, 1.813]	0.061	0.592
	Time	−0.228	0.0511	94.1	−4.45	<0.001	[−0.328, −0.127]		
LSNS-6	Intercept	2.310	0.1206	78.3	19.15	<0.001	[2.074, 2.547]	0.010	0.668
	Time	0.116	0.0574	93.4	2.02	0.047	[0.00321, 0.228]		

The estimates, standard errors, degrees of freedom, t-values, *p*-values, and confidence intervals are presented for each fixed effect (intercept and time) across three different models.

improvements as the therapy continued. One possible hypothesis for the initially higher scores given by family members is that network meetings provide immediate relief by offering support and a sense of being heard, which alleviates their sense of isolation. In contrast, the impact on the well-being of the patient in crisis may take longer to manifest, as the therapeutic process needs time to unfold and address deeper issues. Overall, these findings underscore the value of using both scales to capture different dimensions of the therapeutic experience.

With regard to the effectiveness of the Open Dialogue (OD) approach in enhancing mental health outcomes within the Italian context, this study documents clear clinical improvements across several key indicators. Over a 12-month period, the application of OD principles in network meetings correlated with significant positive changes in the Global Assessment of Functioning (GAF), Clinical Outcomes in Routine Evaluation (CORE-OM), and the Lubben Social Network Scale (LSNS). These findings are particularly noteworthy given the diverse and comprehensive measures employed to assess therapeutic progress.

The use of a linear mixed-effects model provided robust insights into the longitudinal data, revealing a substantial effect of time on all assessed outcomes. Notably, GAF scores showed a significant increase, suggesting improved psychological, social, and occupational functioning among participants. Similarly, CORE-OM scores indicated a decrease in psychological distress and an enhancement in well-being, which aligns with the core objectives of OD in promoting recovery through dialogue and network involvement. Additionally, LSNS scores demonstrated an increase, reflecting strengthened social networks and support systems, which are vital for sustainable mental health recovery.

These findings underscore the potential of the Open Dialogue approach to not only facilitate immediate improvements in mental health conditions but also to contribute to long-term wellness and social integration. The positive trajectory of these clinical outcomes over the study period highlights the value of incorporating network-based, dialogic practices in mental health services, particularly within systems like Italy's National Health Service that emphasize community-based care.

4.1 Comparison with previous research on Open Dialogue

Overall, this study confirms the feasibility of integrating Open Dialogue into the mental health services of Italy, showcasing its adaptability beyond its original implementation in Lapland as

evidenced by analogous research conducted in diverse settings (Kłapciński and Rymaszewska, 2015; Gordon et al., 2016; Kinane et al., 2022). Contrary to other healthcare systems where fragmentation (Heumann et al., 2023), diagnosis-specific services (Kinane et al., 2022), and limitation in the costs covered by insurance (Gordon et al., 2016) have been identified as significant impediments, the Italian model distinctly facilitates this approach. In fact, the Italian mental health system, characterized by community-based services that deliver continuous therapeutic support, employs a trans-diagnostic approach within a universally accessible public framework devoid of insurance-based constraints.

It is crucial to highlight that in this study, both outcome and process data collection commenced only after the participating teams had undergone a year of foundational training with expert Finnish trainers and had demonstrated satisfactory fidelity to the organizational and dialogical principles (Pocobello and el Sehity, 2017; Ciliberto et al., 2017; Pocobello, 2021). Fidelity and adherence assessments during network meeting analyses were conducted using unpublished scales that are based on the principles outlined by Olson et al. (2014). These scales, as reported also by Kinane et al. (2022), not only facilitated the evaluation of adherence and fidelity but also significantly aided in the reflection and improvement processes within the teams. Such evaluations are not merely beneficial—they are essential, as both a literature review (Freeman et al., 2019) and an international survey (Pocobello et al., 2023) have underscored the profound challenges of adopting Open Dialogue with full fidelity to its foundational principles across diverse services.

The findings reported in this article suggest that Open Dialogue network meetings are associated with positive clinical outcomes, including reductions in psychological distress, improved overall functioning, and enhanced social networks. These outcomes align with those reported by Seikkula et al. (2011) in Lapland, though there are notable differences in the study populations and methodologies. Unlike Seikkula et al., who focused on patients experiencing initial psychotic episodes, our study included a more diverse sample across a shorter timeframe of one year. Similar improvements have also been reported in pilot studies in the US (Gordon et al., 2016) and the UK (Kinane et al., 2022), where significant enhancements in well-being and functioning were observed.

Patients and their families consistently reported high levels of satisfaction with both the individual therapy network meetings and the overall treatment outcomes, mirroring findings from earlier research in Lapland, which correlated positive clinical outcomes with high satisfaction rates when engaging the entire social network in treatment (Seikkula et al., 2001). Similar positive outcomes in patient and social network satisfaction have been observed in studies outside of Lapland. For example, a study by Gidugu et al. (2021) in the United States also reported high appreciation levels from both patients and families, highlighting the distinctive benefits of Open Dialogue, particularly its emphasis on social network involvement, transparency, respectfulness, and collaborative nature. Additionally, in their study in the UK, Kinane et al. (2022) reported that Peer Supported Open Dialogue received a notably high score of 9.19, which is significantly higher than the score of the same Trust (6.51) and the national average (7.03). These findings collectively suggest that OD effectively meets the expectations and needs of patients and their families within the mental health care context.

In our study, the annual frequency of network meetings was notably lower, with 517 meetings recorded, compared to the 467 meetings reported by Kinane et al. (2022) over a six-month period. This variation may be attributed to a lower threshold for service access in the Italian context, potentially indicating that some patients presented with less severe clinical conditions than those observed in the British study. Concerning social network participation, our findings showed greater involvement in Italy than in the UK, with social network participation accounting for 69.4% of the meetings, compared to 52.5% in the UK. These differences in social network participation could be influenced by several factors, including the prominent role of families in Italian culture and a well-established systemic tradition in mental health care.

4.2 Implications for the implementation of Open Dialogue

This study confirms the feasibility of integrating the Open Dialogue (OD) approach within Italian mental health departments. It demonstrates that professionals can be effectively trained and equipped to adopt this innovative model in a community mental health system ideally suited for OD. Notably, department directors interviewed before the implementation recognized OD's compatibility with the Basaglia Reform, viewing it as a means to "relaunch" it (Pocobello, 2021). In particular, services such as those in Trieste had already aligned with the first five organizational principles of OD prior to its introduction. Therefore, the training focused primarily on the dialogic principles of dialogism and tolerance of uncertainty—relatively novel concepts across these services, which became the central themes of the training and supervision sessions (Pocobello and el Sehity, 2017).

Furthermore, the positive outcomes observed suggest that OD offers tangible benefits to patients within the Italian mental health system and is highly valued by both patients and their families. Its successful implementation in diverse urban and rural contexts also underscores the potential for scaling the OD approach across the country.

However, the long-term effectiveness of OD depends crucially on sustained monitoring and supervision. Although the project demonstrated effective management of fidelity and adherence, the end of the project introduces a risk of standards slipping without continuous oversight. This underscores the urgency of establishing permanent mechanisms to ensure that high standards of OD practice are maintained over the long term.

Overall, this study makes a compelling case for considering OD as a valuable addition to existing mental health practices in Italian healthcare settings, encouraging further exploration and integration of this model into routine care protocols.

Among the lessons learned from the Italian OD program, extensive training in OD with expert trainers seemed crucial for successful implementation. The selection process, where departments chose candidates based on voluntary participation and intrinsic motivation, appeared effective in ensuring that those trained were genuinely committed to the OD approach. This commitment seems essential for the sustainability and fidelity of OD practices. Future implementations might benefit from continuing to prioritize voluntary and motivated participation in training programs.

The project also highlighted several systemic challenges, including the need for consistent funding, administrative support, and alignment with national health policies. Addressing these challenges could be crucial for the broader implementation of OD. Policymakers and health administrators might need to recognize the value of OD and allocate resources to support its integration into mental health services.

Furthermore, research has appeared fundamental in addressing the challenges encountered during implementation. It has played a key role in promoting the quality of the intervention and fostering a reflective attitude in both clinical practice and implementation processes. Research has also been important for maintaining the network of services and creating a professional network that has extended well beyond the initial project timeframe.

4.3 Limitations and future directions

This study has several notable limitations. First, the relatively small sample size of 58 participants may limit the generalizability of the findings. Additionally, the sample size shrunk over time due to attrition, which could introduce bias and affect the robustness of the results.

The absence of a control group makes it difficult to definitively attribute the observed changes at the three time points to the Open Dialogue approach rather than to natural progression over time. Furthermore, the 12-month follow-up period may be too brief to fully capture the long-term effects and sustainability of the improvements. This underscores the need for extended monitoring to more accurately assess the durability of the outcomes.

Another limitation is the use of the Session Rating Scale (SRS) and Outcomes Rating Scale (ORS). Although these scales are widely used in clinical settings, their application in research may be considered a limitation due to potential biases and the subjective nature of self-reported data. However, these scales also offer a significant strength to the study. They effectively capture the experiences of end users, providing valuable insights into client satisfaction and the therapeutic relationship.

Looking ahead, future research should focus on long-term, large-scale longitudinal studies to better understand the sustained impacts of OD. Moreover, there is a significant gap in cost-effectiveness analyses, which are essential for evaluating the economic viability and potential for broader application of OD.

5 Conclusion

The findings of this study reflect a significant affirmation of the Open Dialogue (OD) approach within the Italian mental health service context, underscoring its potential as a transformative model for mental health care. The consistent improvements in Global Assessment of Functioning (GAF), Clinical Outcomes in Routine Evaluation (CORE-OM), and the Lubben Social Network Scale (LSNS) over the 12-month period demonstrate the effectiveness of OD in enhancing psychological well-being, social functioning, and network support among participants.

The study highlighted the value of the OD approach in fostering substantial client and family engagement, which is crucial in mental health recovery. The Session Rating Scale (SRS) and Outcome Rating Scale (ORS) evaluations illustrated high satisfaction levels and perceived positive outcomes, reinforcing the relational and collaborative foundation of OD. These positive evaluations from clients and their networks not only validate the approach but also illustrate its capacity to create a supportive and effective therapeutic environment.

Looking to the future, these results suggest that integrating OD principles into broader mental health services could substantially improve care outcomes. The emphasis on immediate, flexible, and continuous care, in alignment with individual needs and involving a support network, aligns well with current shifts toward more personalized and patient-centered care models in mental health services globally.

Moreover, the successful implementation of OD in Italian MHDs, which shares characteristics with Finland's public and community-based healthcare system, suggests that this approach can be adapted to diverse health systems with varying resources and cultural contexts. This adaptability is crucial for the expansion of OD and highlights its potential for adoption in other regions seeking innovative and effective mental health solutions, particularly in systems that prioritize public health and community engagement.

In conclusion, the integration of OD into Italian MHDs not only enhances clinical outcomes but also embodies a shift toward more humane, responsive, and effective mental health care. By continuing to foster research, training, and implementation of OD, there is potential for a significant paradigm shift in how mental health care is delivered worldwide. This could lead to systems that not only manage symptoms but also empower individuals and their communities, contributing to a more holistic approach to mental health and well-being.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by Ethical committee of the Institute of Technologies and Cognitive Sciences-National Research Council: ISTC-CNR-20170207 and of the ethical committees of each mental health department participating in the study. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

RP: Conceptualization, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. FC: Writing – original draft, Writing – review & editing. PR: Project administration, Writing – review & editing, Data curation. GC: Project administration, Writing – review & editing, Data curation. MB: Project administration, Writing – review & editing, Data curation. GT: Project administration,

Writing – review & editing, Data curation. MM: Project administration, Writing – review & editing, Data curation. Md'A: Project administration, Writing – review & editing, Data curation. EG: Project administration, Writing – review & editing, Data curation. TS: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing, Supervision, Visualization.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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The first Portuguese Open Dialogue pilot project intervention

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Introduction: In 2020, the Directorate General of Health (DGS), a central service of the Ministry of Health in Portugal, approved and co-financed the first Open Dialogue program in the country. The present report aims to demonstrate the preliminary results of the first year of the project, implemented in the northern interior region of Alentejo.

Methods: Seven people at the Center of Concern (PCC) and 21 family members/social networks received care through Open Dialogue; four external social workers and psychologists were also involved in the project as members of the support network. A total of 160 network meetings were undertaken, reaching as many as 27 per month in the busiest periods. Based on a previous Italian Research Protocol, developed by Pocobello et al. (non-published manuscript), quantitative and qualitative data were collected in and after the clinical meetings involving PCC and their family/social network, through a multi-method approach: clinical history interview (e.g., generic research on sociodemographic data, duration of untreated symptoms, reasons for requesting help, possible hospitalizations, and/or treatments/therapies) and the following scales applied every five sessions (e.g., CORE-OM, BSI, GAF, and LSNS-6).

Results: The preliminary results indicate an improvement in global functioning and the enlargement of social network size/support, a decrease in symptoms, and a negative correlation between the number of sessions and the LSNS6. Medication use remained largely unchanged at the end of the project.

Discussion: In general, even with a small sample, the results are considered satisfactory and seem to be aligned with the vast majority of Open Dialogue studies, which for several decades have consistently pointed toward better recovery rates than treatment as usual as well as increased client satisfaction. We expect that the results presented can boost further research and help strengthen the OD approach.

KEYWORDS

Open Dialogue, psychiatric crisis, dialogic practice, democratic approaches, mental health care

1. Introduction

Open Dialogue (OD) is a Finnish therapeutic approach and an organizational system of mental health services aimed at responding to psychiatric crises. OD was inspired by the need-adapted treatment of Alanen (1997, 2009) and based on psychodynamic therapy, family therapy, dialogical practices, and network approaches. Efforts were undertaken to allow for an immediate response at the onset of a psychotic crisis. This study aimed to create a psychotherapeutic and dialogical space—particularly within the so-called network meetings—where the Person at the Center of Concern (PCC) would participate together

with his/her family and/or support network. Priority is given to transparent and shared decision-making in a dialogical format (Altonen et al., 2011).

Open Dialogue has faced several adaptations according to different contexts and countries. Nevertheless, a set of principles remain central to the accurate implementation of OD practice: immediate help, social network perspective, responsibility, flexibility, mobility, tolerance of uncertainty, and dialogism (Seikkula and Olson, 2003; Pereira et al., 2019). The team aimed to create a therapeutic space that tolerates uncertainty while letting understanding unfold from multiple perspectives, allowing for natural resolution when possible (Olson et al., 2014). Treatment plans and decisions are made in co-participation and transparently.

OD has been systematically evaluated over the last three decades (Lakeman, 2014; Freeman et al., 2019; Kantorski and Cardano, 2019; Cooper et al., 2020), showing promising results regarding returning to work and/or academic activities (Seikkula et al., 2006, 2011; Altonen et al., 2011; Alakare and Seikkula, 2022), reduction of psychiatric symptoms (Gordon et al., 2016), relapses (Seikkula et al., 2011), days of hospitalization (Altonen et al., 2011; Bergström et al., 2018), use of anti-psychotic medication, and allocation of disability and unemployment benefits (Bergström et al., 2018; Alakare and Seikkula, 2022). Poor quality social networks and delays in assistance during psychiatric crises lead to a higher frequency of hospitalizations and a propensity for anti-psychotic medication use (Seikkula et al., 2001).

OD presents itself as an alternative to the traditional perspectives based on the problem–diagnosis–treatment triad (von Peter et al., 2019). It is currently recognized by the World Health Organization (WHO) as good practice in psychiatric crisis, as well as a recovery and human rights supporter. It is also present in the Council of Europe's good practice compendium, whose purpose is to eradicate coercive practices in mental health settings (Mosse et al., 2023). This reinforces OD's alignment with human rights—a worldwide concern in the context of mental health (von Peter et al., 2019).

Portugal was already known as one of the European countries with the highest prevalence of mental disorders (Direção Geral da Saúde—DGS, 2017) and, according to the data collected in 2020, the country was classified with the highest prevalence (23%) of symptoms associated with psychological issues (Entidade Reguladora da Saúde—ERS, 2023) as well as one of the highest uses of psychotropic drugs in the EU (Almeida et al., 2013). There are serious difficulties in the identification, treatment, and follow-up of adults with mental disorders, which is reflected in the excessive use of hospital emergencies and the high rate of involuntary hospitalizations (ERS, 2023).

These problems are also a consequence of the scarcity and lack of human resources in psychology and psychiatry. The current number of psychologists is far below the recommended ratio of 1 psychologist per 5,000 inhabitants, currently at 1 per 9,687 inhabitants (Ordem dos Psicólogos Portugueses—OPP, 2022). This problem anticipates constraints in accessing psychological help.

Alentejo exhibits the highest ratio of depression, anxiety, and suicide (ERS, 2023) in the country. A total of 5.4% of the population is illiterate, compared with 3.8% in the rest of the country. It is the region with the lowest population density, the highest aging/longevity index, and one of the highest unemployment rates in the country (Instituto Nacional de Estatística—INE, 2022b).

In this context, OD should be seen as a new (respectful) way of understanding and responding to mental health problems, accessible to the Portuguese health system.

The research protocol for assessing the transferability of the OD approach to the context of North Alentejo mental health services included different levels of evaluation: (1) perceptions of the mental health service managers of the region; (2) evaluation of the impact of OD training in the Romão de Sousa Foundation clinical team, as well as in its clinical practice; (3) adherence evaluation; and (4) therapeutic outcomes.

The Romão de Sousa Foundation set up a small OD crisis team composed of two clinical psychologists with an advanced specialty in psychotherapy, one clinical psychologist with a PhD in psychotherapy—coordinator, and one psychiatrist. They were all trained in Open Dialogue up to the practitioner level, with training in Finland, Norway, the United States, and Portugal. The external supervision during the project was undertaken by Professor Mary Olson from Yale University and the Institute for Dialogic Practice in the United States. The team operated 5 days a week with the aim of improving the quality of services (psychiatric, psychological, and social) for the population in severe mental distress and the psychosocial and socio-professional empowerment and capacity building of people in the center of concern. Throughout the program, all the procedures that ensure the fidelity of OD practices were adopted, such as video recording of all sessions for supervision and audit purposes.

The present study aimed to analyze the preliminary clinical results of the first year of the Portuguese Open Dialogue program implemented in the northern interior of the Alentejo region. We would like to know whether the results of the program follow the international trend of OD results, particularly regarding the improvement in participants' global functioning and the reduction of psychopathological symptoms. We also want to know whether certain sociodemographic variables (e.g., social network support) are related to clinical outcomes.

2. Materials and methods

2.1. Study design

This exploratory study is a naturalistic observational cohort of consecutive referrals of clients with psychiatric diagnoses treated with the OD approach. A prospective follow-up design was used, comparing baseline scores of client-level outcomes at every five sessions for 12 months.

2.2. Sample

In the initial sample, there were 11 eligible participants. However, due to the loss of interest and/or incompatibilities with the modality of the meetings, which were forced to be online due to COVID-19 confinement, the final sample ended with seven participants.

2.3. Sociodemographic and clinical characterization

Study participants had to be aged between 14 and 65 years, experiencing psychotic symptoms or other diagnoses of severe mental disorders, presenting for emergency services voluntarily, able to provide informed consent, and willing to have family and other social networks participate in the meetings. The final sample was composed of seven participants, five were female participants (71.4%) and two were male participants (28.6%); four of them were employed and/or in training, two were unemployed (one short-term and one long-term), and one was retired.

Regarding hospitalization, only one participant (14.3%) referred to being in a hospital or other residential structure before joining the Open Dialogue Project. Concerning suicide attempts, three participants (42.9%) declared having attempted suicide, and one participant (14.3%) presented self-harm behavior. Regarding medication, six (85.7%) participants were under psychiatric prescriptions at the onset, undertaken by professionals external to the treatment/research team, more precisely professionals who accompanied the participants before entering the project. After enrolling for OD treatment, it was the OD team psychiatrist that took responsibility for any changes in medication, in line with the characteristic OD joint decision-making during network meetings. There was only one exception in which the previous psychiatrist retained prescription responsibility and was invited to network meetings. Concerning extra-familial social relationships, six participants reported that they did not feel satisfied with their social relationships.

2.4. Procedures of participant screening and enrollment

Data were collected through non-random (objective) sampling. The OD treatment clients (and then the study participants) were recruited among clients who have access to mental health services at different levels (e.g., inpatient ward and mental health crisis service), through community structures such as the Commission for the Protection of Children and Young People (CPCJ), the Centre for Family Support and Parental Counselling (CAFAP), the Norte Alentejano Local Health Unit (ULSNA); leaflets distributed in Pharmacies, Social Centers, Town Hall; Internet; and Casa de Alba Therapeutic Community. Referrals were largely undertaken by the applicant's family and extended network or by the applicant himself or herself. All the participants who voluntarily agreed to participate in the OD treatment also consented to be part of the research sample. However, OD treatment and research were independent and required separate consent forms, so it was not mandatory to participate in both to be eligible for OD treatment. The participants were diagnosed with several disorders, such as anxiety disorders, affective disorders, psychotic disorders, and other situations such as suicidal ideation, emotional dysregulation, severe difficulties in relationships and in maintaining daily activities, and a moderate or high degree of psychosocial disability resulting from mental health problems. The diagnoses were not carried out by the OD clinical team but by clinicians from public or private health services who previously had contact with the participants.

The eligibility criteria for OD pilot project participants were being aged between 14 and 65, experiencing psychotic symptoms or other severe mental disorder diagnoses, voluntarily presenting to emergency services, being able to provide informed consent, and willing to have family and other social networks participate in the meetings. Members of the clinical staff were instructed about screening potential participants and evaluated to determine whether they were eligible for the study. Clinicians informed eligible clients about the possibility of taking part in the study and, when possible, registered reasons for eventual refusals. Once the participants had signed the informed consent, the enrollment was considered complete. The OD clinical and research teams were independent, except for the coordinator and last author of this article, who has been involved in both; however, most of the research team members have held or are holding positions at the Romão de Sousa Foundation, the institution that ran the clinical project. After accepting to participate in the research, the participants filled out the proposed questionnaires to monitor the process. The questionnaires, applied by the OD clinical team, were planned to be repeated every five sessions, but collection procedures became more complex with the start of the COVID-19 pandemic, and we only used data from baseline and after treatment. 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. Due to the COVID-19 pandemic, the program setting was forcedly adapted to the needs of the context with most contacts, and so OD meetings and assessments were performed remotely from the second month of the project onward, despite being initially designed to take place in a location of the participant's preference. At the end of treatment, 151 meetings were held online (94%) and only nine meetings (6%) were held in person.

This research was reviewed and approved by the Ethics Committee of the *Universidade de Évora*.

2.5. Instruments

OD feasibility was assessed through a set of quantitative and qualitative data, collected in/and after the clinical meetings involving people in the center of concern and their families/caregivers, through a multi-method approach: clinical history interview (e.g., generic research on sociodemographic data, duration of untreated symptoms, reasons for requesting help, possible hospitalizations, and/or treatments/therapies) and the following self-report scales applied every five sessions: CORE-OM (Sales et al., 2012, original from Evans et al., 2002), BSI (Canavarro, 1999, original from Derogatis and Spencer, 1982), GAF (Endicott et al., 1976), LSNS-6 (Ribeiro et al., 2012, original from Lubben et al., 2006), and a Satisfaction questionnaire. In this article, we only present part of these data, namely the ones related to the participants' sociodemographic and clinical characterization, and their therapeutic outcomes.

Regarding the instruments, the Clinical Outcomes in Routine Evaluation—Outcome Measure (CORE-OM) instrument consists

of 34 items, on a scale from 0 to 4, distributed by wellbeing, problems/symptoms, life functioning, and risk to self and others domains, measuring psychological distress and essential aspects of psychological wellbeing over the last week (Sales et al., 2012). The cutoff is 1.25, with higher scores meaning greater severity of symptoms and distress.

The Portuguese Brief Symptom Inventory (BSI) is a self-assessment questionnaire, referring to the last week and consisting of 53 items, on a scale from 0 to 4, including nine dimensions: somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The scale seeks to provide summary indices of the levels of psychopathological symptoms (Canavarro, 1999). The higher the scores, the greater the degree of symptomatology.

The Global Assessment of Functioning (GAF) Scale is divided into 10 sections and aims at assessing the impairment caused by mental disorder in psychological symptoms, social, and occupational functioning, i.e., how much individual symptoms affect daily life, on a scale from 0 to 100, with a 100 score evidencing superior functioning with no symptoms that impair functioning; from 61 to 70 some mild symptoms (e.g., depressed mood and mild insomnia), or some difficulty in social, occupational, or school functioning but generally functioning well, with some meaningful interpersonal relationships; from 41 to 50 serious symptoms (e.g., suicidal ideation, severe obsessional rituals, and frequent shoplifting) or any serious impairment in social, occupational, or school functioning; and scores below 21 as some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, and manic excitement) or occasionally fails to maintain minimal personal hygiene or gross impairment in communication (Endicott et al., 1976).

The Lubben Social Network Scale (LSNS-6; Ribeiro et al., 2012) aims to assess people's social isolation and obtain information about the type of social relationships, the size of the network, and the intimacy with support network members. The LSNS-6 consists of six items distributed in two subscales, the Family subscale and the Friends subscale. The scale scores range from 0 to 30 on a 5-point Likert scale.

The satisfaction questionnaire was measured on a 0 to 10 scale.

2.6. Data analysis

A paired samples *t*-test was run for the preliminary exploration of the GAF, BSI, CORE-OM, and LSNS6 general clinical outcomes, which included data from baseline and the end of therapy. The Shapiro–Wilk test was run to verify normality distribution. Furthermore, we ran a series of bivariate correlations (Pearson's) among the variables age, number of meetings, satisfaction, program duration, and the scores of the last period of the clinical instruments. For the statistical data analysis, IBM-SPSS 28.0 was used.

3. Results

Table 1 summarizes the survey results, showing the scores for the GAF, BSI, CORE-OM, and LSNS6, including the baseline and final period results, as well as statistical data.

The GAF test results showed that the participants' scores of global functioning increased from baseline (M = 57.71; SD = 10.468) to the last period (M = 65.71; SD = 11.398); [$t_{(6)} = -2.506$; $p = 0.023$; g = −0.887), with statistical significance evidence and Hedges' g large effect.

The BSI test results showed that the participants' pathological symptomatology scores decreased from baseline (M = 1.585; SD = 0.744) to the last period (M = 1.078; SD = 0.350); [$t_{(6)} = 1.921$; $p = 0.052$; $g = 0.631$), marginally non-significant statistically.

The CORE-OM test results showed that the participants' psychological distress symptom scores decreased from baseline (M = 1.899; SD = 0.883) to the last period (M = 1.252; SD = 0.343); [$t_{(6)} = 1.712$; $p = 0.069$; $g = 0.562$], which was non-significant statistically.

The LSNS-6 test results showed that the participants' social network size/support increased from baseline (M = 12.429; SD = 5.533) to the last period (M = 13.429; SD = 4.315); [$t_{(6)} = -0.548$; $p = 0.302$; $g = -0.194$], even so, non-significant statistically.

Table 2 summarizes the outputs of the bivariate correlations among the variables age, number of meetings, satisfaction, program duration, and the scores of the last period of the clinical instruments.

A very strong negative correlation between the number of sessions and the LSNS6 score was found ($r = -0{,}896$; $p = < 0.01$).

The participants' satisfaction mean score was 9.5 on a scale from 0 to 10, with 10 being the best score. Additionally, some of them expressed words of gratitude regarding the support received by the OD clinical team, e.g.,: *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*".

At the end of the program, psychiatric prescriptions were kept by the participants who were using them at the beginning.

4. Discussion

According to the data, the OD approach presents favorable results, showing increased levels of global functioning and social network, as well as decreased symptomatology. The increment of GAF scores from moderate symptomology (from 51 to 60; usually with a predominance of flat affect and difficulties in social, occupational, or school) to a higher range score (from 61 to 70), evidence of less severe symptomatology (as depressed mood and mild insomnia), a tendency to improve personal relationships, and a positive level of functioning. Furthermore, one of the participants who was on medical leave returned to work, and another enrolled in university and joined OD training as a peer. These individual examples seem to sustain the quantitative measures that indicate functional improvement. Along with these results, we also observed an enlargement of the social network size, although it was residual. The family's and/or social network's participation in the dialogic process is highly encouraged due to their potential to become active allies, and their participation is expected to increase mutual understanding. The tendency to earlier relapses in people with low

TABLE 1 Paired samples *t*-test for GAF, BSI, CORE-OM. and LSNS6.

	M (baseline)	SD (baseline)	*M* (final)	SD (final)	*t*	df	*p*	Hedges' G
GAF	57.71	10.468	65,71	11.398	−2.506	6	0.023	0.887
BSI	1.585	0.744	1.078	0.350	1.921	6	0.052	0.631
CORE-OM	1.899	0.883	1.252	0.343	1.712	6	0.069	0.562
LSNS6	12.429	5.533	13.429	4.315	−0.548	6	0.302	−0.194

GAF, Global Assessment of Functioning; BSI, Brief Symptom Inventory; CORE-OM, Clinical Outcome Routine Evaluation—Outcome Measure; LSNS, Lubben Social Network Scale; M, mean; SD, standard deviation; *t*, student's *t*-distribution; *df*, degrees of freedom; $\alpha = 0.05$; *p* (one-tailed).

TABLE 2 Pearson's correlations among the variables under study.

	1	2	3	4	5	6	7	8
Age	–							
Number of meetings	0.440	–						
Satisfaction with programme [a]	0.223	0.014	–					
Programme duration [b]	0.355	0.579	0.590	–				
GAF [c]	−0.323	−0.083	0.041	0.537	–			
BSI [c]	0.160	0.402	−0.661	−0.104		–		
CORE-OM [c]	0.647	0.177	−0.096	−0.131			–	
LSNS6 [c]	−0.574	−0.896*	0.018	−0.402				–

GAF, Global Assessment of Functioning; BSI, Brief Symptom Inventory; CORE-OM, Clinical Outcome Routine Evaluation—Outcome Measure; LSNS, Lubben Social Network Scale.
[a]Mean scores.
[b]Months.
[c]Final scores.
*$p < 0.01$.

socialization levels is known (Johnstone et al., 1992, cite in Seikkula et al., 2001), even when among the first episodes of psychiatric crises the network size was found to be similar to that of the non-clinical population.

Efforts must continue to try to guarantee that factors such as social and family meaningful interactions are not neglected due to their importance to the recovery process and relapse prevention (McFarlane, 2016; Day and Petrakis, 2017; Johansen et al., 2021).

BSI and CORE-OM scores also decreased at the end of the project, which indicates that participants were under less psychological distress and more able to experience wellbeing, although other factors may have contributed to this outside therapy. A very strong negative correlation was found between the number of sessions attended and the LSNS6 final score, and due to our small sample size, we easily realized that the participants who attended more OD meetings scored lower on the LSNS6 at the end of the program. Although correlation does not imply causation, this result makes us wonder, once more, about the importance of family/social support and how the OD team might have, in some way, replaced the ones who were not available (or did not even exist). Although challenging, it is relevant to project how services can be adapted to the singular reality of each person looking to decrease perceptions of lack of support and improve integration into the community in a sustainable and fulfilling way. The data will be further analyzed to search for other possibly meaningful interactions. Follow-up outcomes are expected, so more conclusions about the OD's long-term outcomes can be reported.

As limitations of this research, we highlight the small sample size and the constraints due to the COVID-19 pandemic, which impact the adherence and retention of the participants, as the meetings were forcedly migrated online (94%), and some of them were not able to meet certain technological needs.

In Portugal, 26.6% of the population aged 16 or over reported a negative effect of the COVID-19 pandemic on mental health in 2021 (INE, 2022a). As the project occurred during the first year of the pandemic, we wonder about the possible influences it may have had on our sample and the consequent impact on outcomes, despite not being assessed. The non–self-report measure (GAF) was applied by all members of the clinical team present in the network meeting, rated blindly and immediately after the session, with the lowest number being recorded. The aim of using GAF was to increase the confidence of the self-reported measures by analyzing whether there was concordance between them. Satisfaction was not assessed; neither for network support members nor the clinical team. In addition, family/social relationship satisfaction was not assessed post-intervention. Furthermore, a more comprehensive satisfaction questionnaire would have provided better insight into the aspects valued by participants during the process.

Another limitation was the impossibility of getting access to Treatment as Usual results from the local health authority

so that a comparison could be made. ERS (2023) identifies the need for improving IT systems, which currently lack systematization of information regarding the registration and control of health system beneficiaries. This aspect seems essential to an effective characterization of the population and follow-up procedures.

Despite the alarming facts regarding the higher incidence of mental health problems in this region, it is worth mentioning that efforts are being made to counter the rooted lack of investment in mental health in Alentejo.

In general, even with a small sample and with the limitations presented, the results seem to be aligned with the vast majority of Open Dialogue studies, which for several decades have consistently pointed toward better recovery rates than Treatment as Usual results as well as increased client satisfaction. Although not all the mean differences were statistically significant, these preliminary results are considered satisfactory, and agreeing with the fact that there is still much to be explored about OD and the transformations that its practice can bring (Mosse et al., 2023), we expect that the results presented here can boost further research and help strengthen the OD approach.

We also speculate that future Open Dialogue studies could include participants with generic mental health problems and not just psychosis as most Open Dialogue studies have performed so far.

Finally, we believe that future clinical trial results will help clarify the benefits of Open Dialogue and help give meaning and significance to small reports of this kind.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving humans were approved by Ethics Committee of Évora University. The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation in this study was provided by the participants' legal guardians/next of kin. Written informed consent was obtained from the individual(s), and minor(s)' legal guardian/next of kin, for the publication of any potentially identifiable images or data included in this article.

Author contributions

JP and ST provided guidance and supervision for the process. All authors contributed to the article and approved the submitted version.

Conflict of interest

JP, SG, and BA were employed by Romão de Sousa Foundation.

The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

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The contribution of anthropology to the study of Open Dialogue: ethnographic research methods and opportunities

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When Open Dialogue diversifies internationally as an approach to mental healthcare, so too do the research methodologies used to describe, explain and evaluate this alternative to existing psychiatric services. This article considers the contribution of anthropology and its core method of ethnography among these approaches. It reviews the methodological opportunities in mental health research opened up by anthropology, and specifically the detailed knowledge about clinical processes and institutional contexts. Such knowledge is important in order to generalize innovations in practice by identifying contextual factors necessary to implementation that are unknowable in advance. The article explains the ethnographic mode of investigation, exploring this in more detail with an account of the method of one anthropological study under way in the UK focused on Peer-Supported Open Dialogue (POD) in the National Health Service (NHS). It sets out the objectives, design and scope of this research study, the varied roles of researchers, the sites of field research and the specific interaction between ethnography and Open Dialogue. This study is original in its design, context, conduct and the kind of data produced, and presents both opportunities and challenges. These are explained in order to raise issues of method that are of wider relevance to Open Dialogue research and anthropology.

KEYWORDS

anthropology, ethnography, Open Dialogue, mental health, psychiatry implementation, practices, research methods psychiatry

Introduction

As Open Dialogue (OD) gains traction as an alternative to established approaches to psychiatric care worldwide, research methods to measure therapeutic outcomes and explain the clinical and social complexity of this approach have also proliferated. In this context, anthropology, and its core method of ethnography, opens opportunities to explore the nature, significance and implications of Open Dialogue in specific local contexts. In the following article, we describe the contributions of anthropology in mental health research and highlight its unique approach to investigation through an in-depth account of an ongoing anthropological study on Peer-Supported Open Dialogue (POD) within the UK's National Health Service (NHS). This will show how the method allows examination of the process and context of the Open

Dialogue approach, as well as its affective and structural dimensions. Knowledge on such aspects of a mental healthcare intervention are often critical to improving or extending innovations, yet rarely the focus of standard quantitative and qualitative evaluations.

The anthropological method

The anthropological method is often characterized as the combination of three things. First, is the immersive experience of the phenomenon being studied through what is rather misleadingly called "fieldwork." This involves extended encounters with people, institutions or processes through so-called "participant observation," so as to allow an everyday experience of the situations under investigation, usually for a year or so. Second, it involves the contemporaneous documentation of this experience of events, social exchanges or institutional processes, that is, the keeping of "fieldnotes." With Clifford (1990) we can think of fieldnotes as moments of "inscription" (a turn away from unfolding events to jot or to take note of a conversation or activity immediately afterwards), "transcription" (noting answers to specific questions or queries, transcribing a tale or social rule) and "description" (producing a representation of events or encounters involving analysis and interpretation). Fieldnotes variously turn moments into documents so they can be remembered and revisited as a "recontextualized, portable account" (1990, 64).

There is much besides that anthropologists do, including interviewing, the conduct of surveys (household, opinion and others), the analysis of social networks, key events or situations, the observation of environmental and architectural space, and assembling and review of policy documents, visual, audio and other media, including photos, posters, maps, songs, newspapers, emails and social media. But still, the core of the method generative of research data is immersive participant observation and notetaking.

The third element of the anthropological method aims to place the observations and experience of participant observation into wider contexts. This is both a matter of examining the social, institutional or historical connections that establish the significance of what comes out of direct experience, and using a body of theory and comparative research to open up interpretive possibilities from empirical description. This involves distanciation, a more or less difficult "turning away" (Clifford, 1990, 67), in order to produce contextualized "thick description" (Geertz, 1973, 7–9) of phenomena. This entails forms of writing that evoke through story-telling's capacity to make present and "put culture or society into motion" rather than just to capture in description (Ellis and Bochner, 2006, 431); hence anthropology sits between the sciences and humanities.

The immersive encounters, the documentation in fieldnotes and placing observations in context so as to re-explore meaning and significance, and to evoke experience, together comprise ethnography, the summarizing label for the anthropological method. The practice is iterative in that "fieldnotes are enmeshed in writing and reading that extends before, after, and outside the experience of empirical research" (Clifford, 1990, 64). The thematic coding that begins to organize the vast array of information on happenings, cases, actions, crises, routines (etc.) emerging from ethnographic research data in turn shapes curiosity during participant observation. And the process is inevitably collaborative since, as Latour reminds us, the actors we engage with are themselves social scientists offering each other theories to unify, stabilize and realize given interpretations from which researchers construct meta-narratives (Latour, 1996, 172, 180; Mosse, 2005, 155).

Two further characteristics of ethnographic research need mention: one, it is inductive; the other, it is reflexive. Ethnographic research does not frame and test hypotheses but accumulates descriptions of particular happenings from which patterns emerge in the iterative way mentioned. It explores the specificity of experience and change, while deriving more general points (Csordas, 2021). Cubellis et al. (2021, 2032) explain ethnography's inductive methodological principle in terms of two "heuristics" or practical strategies. One is its attention to informal processes, that is tacit or taken for granted as well as explicit forms of knowledge, often inferred from behavior rather than from statements. So, research takes account of the "backstage" as well as the "front-stage," as Goffman (1959) put it, and roles beyond professional identities or official scripts that are important to what is happening (Cubellis et al., 2021, 2033). A second heuristic of the inductive approach Cubellis et al. point to, is that it is open to the unexpected, to things that unfold and could not have been anticipated or are unintended.

An implication of the inductive approach is ethnography's methodological holism. This refers to its avoidance of pre-defined fields of relevance and adoption of a wide-angled lens. This allows researchers to find interconnections between substantially different phenomena and contexts, material as well as social. Anthropologists are interested in human interactions, but also in the materiality, space and movement (e.g., technology, architecture, transport) that surround and mediate interactions, making associations and affects. Cubellis et al. describe this as ethnography's "relational perspective," its attention to the interdependence of variables and the discovery of relationships "within and between institutions, policies, ethical concerns, and surrounding structures" (Cubellis et al., 2021, 2035).

The claim that ethnography is inductive—its radical empiricism—is qualified by its other characteristic, its reflexivity. Anthropology makes no naïve claim to objectivity. Its principal instrument of research is the anthropologist themselves, their subjectivity and capacity for sociality, including empathy. This means that data are never simply "out there" since observations are "neither separate from, nor prior to, the anthropologist's own frame of interpretation—the pre-existing scheme of objectification that transforms facts into 'evidence' or imputes causation" (Mosse, 2006, 949, referencing Hastrup, 2004, 456, 461). Anthropological understanding, Descola notes, comes from confronting acts/utterances with our own responses to the same circumstances, and from identification with the motivations that may lie behind the actions of others (Descola, 2005, 70), using our "own native experience in order to understand and analyze other people's" (Bourdieu, 2003, 287). We are never passive recording devices. The verbatim is always framed and filtered.

It is this inescapable presence of an anthropologist's categories of interpretation in their descriptions that demands self-scrutiny, and a deliberate reflexivity to consider the effects of their identity, positionality and predispositions, which Bourdieu (2003) referred to as "participant objectivation." It also means that whenever there is recourse to explanations from experience, ours or our subjects, we have to ask what composes, narrativizes and shapes experience in the sense of the "retrospective organization of experience," which is always distinct from the "immediate living through of experience" [see discussion in Throop (2003)].

Anthropology and mental healthcare

Although still a relatively specialist field, the anthropological method is applied to the study of the practice and culture of psychiatry (Littlewood, 1996). This involves studies of different kinds and scales, focused on institutions and their effects on professionals and patients, and taking a view on systems of mental healthcare from outside their own framings, epistemology and ontology (as well as within) so as to scrutinize the language, assumptions and implications of the practices of care (Bruun, 2019, 31).

At one level, anthropological studies look at the historical and institutional production of psychiatric knowledge on illness and treatment, often through close observation of clinical training, clinical practice and healthcare bureaucracies (Sinclair, 1997; Luhrmann, 2001; Armstrong, 2016). Long-term ethnographic engagement with clinicians and patients has produced new understanding of the phenomenology of illness and the meaning around particular diagnoses in their historical, social and political context, whether depression (Kleinman et al., 1985; Kitanaka, 2011; Lang, 2018), PTSD (Young, 1997; Hinton and Good, 2016), eating disorders (Lester, 2019) or psychosis (Jenkins, 2015; Luhrmann and Marrow, 2016), to cite a few classic and book length studies. Meanwhile, the comparative reach of anthropology places Euro-American psychiatry in perspective. Mental healthcare controversies are not the same everywhere. Today, there is not one but many psychiatries, shaped by regional society and politics, whether in Argentina (Lakoff, 2006), China (Kleinman, 1988), Iran (Behrouzan, 2016), India (Ecks, 2014; Pinto, 2014), Japan (Kitanaka, 2008; Ozawa-de Silva, 2021) or Mexico (Duncan, 2018; Reyes-Foster, 2018). Ethnography is key to understanding the complicated interface of modern psychiatry and other healing systems (Desjarlais, 2011; Lang, 2018), including at times of conflict and upheaval (Argenti-Pillen, 2013; Abramowitz, 2014; Theidon, 2014), that is critical to (and critical of) the movement for global mental health (Kohrt and Mendenhall, 2016; Lang and Sax, 2021). And such ethnography makes us aware of the particularity of dominant psychiatric practice, its beliefs, values, rituals, aesthetics, and that there are alternatives.

While anthropology places mental health care in the larger context of history, culture and political economy, its empirical focus is the development and delivery of particular services that become part of people's lives. At this level, anthropologists have contributed richly detailed accounts of the trials and tribulations of everyday clinical practice across a range of models and settings, for example, the routines, exigencies, conflicts and moral dilemmas of community psychiatric workers (Brodwin, 2013) or frontline crisis teams (Anderson, 2006), the disciplining self-work of people in de-addiction (Carr, 2010), depleted moral agency in a recovery-focused rehabilitation program (Myers, 2015), deep connections that may emerge in a "zone of social abandonment" (Biehl, 2013), or communities forged for innovation in responses to psychosis (Nakamura, 2013).

"Clinical ethnography" refers to those few experience-enriched studies by clinician-ethnographers on (or informed by) their own practice (Kleinman, 1988; Krause, 1998; Davies, 2009; Schechter, 2014). Some anthropologists bring experience of their own diagnoses to analysis of the culture and politics of psychiatry (Martin, 2009). A few combine ethnographic insights as patient, clinician and anthropologist, as in Lester's (2019) remarkable study of eating disorders in the United States.

Anthropology and Open Dialogue

Open Dialogue is an approach to crisis and serious mental illness that reorients psychiatry from its conventional diagnostic to a dialogical approach, and from the focus on individual psychopathology to social relationships as the target of therapeutic interventions. It changes the context of mental health care through clinicians working as a team (at a minimum, two, and the same ones) with people in crisis and any of their family/network they wish to invite to the core "network meetings," responding immediately to a crisis and thereafter meeting flexibly when, where, and at a frequency determined by the needs of the "network" [for an overview see, Razzaque and Stockmann (2016)]. Open Dialogue focuses on the therapeutic relationship as a key factor in health care, on collaborative meaning-making by facilitating different voices, and developing practitioner capabilities for presence, listening and responding. The Open Dialogue approach is summarized in its seven core principles: immediate help, a social network perspective, flexibility, responsibility, psychological continuity, tolerating uncertainty and dialogism. (ibid) It is a non-diagnostic approach that relocates expertise and decision-making and thus has implications for the structuring of teams, roles, record-keeping, time allocation and professional and clinical boundaries. Open Dialogue is therefore not just a therapeutic approach, but a way of organizing mental health services (*ibid*).

Open Dialogue was developed through a body of research emerging from systemic and family therapy, dialogical theory, and relational/systems approaches [see Anderson (1997), Seikkula and Trimble (2005), Seikkula and Arnkil (2006)]. The model's effectiveness was demonstrated in Finnish non-randomized trials, showing dramatically better outcomes for first episode psychosis (Seikkula et al., 2003, 2006). Spreading enthusiasm has seen OD services set up in a total of 24 countries including in Scandinavia, Italy, Germany, UK, Australia, Japan and USA. But a recent review (Freeman et al., 2019) suggested that existing evaluations (23 studies) were of insufficient quality or consistency to justify public investments for delivery at a national scale. Currently, the world's first large-scale randomized controlled trial (RCT) of Open Dialogue—ODDESSI—is running in the UK and will soon provide evidence on the effectiveness of Open Dialogue and its viability within the UK's National Health Service (NHS) in comparison with established treatment models (Pilling et al., 2022).

Open Dialogue has been subject to limited social-scientific research, even though there are a growing number of non-ethnographic qualitative and evaluative studies using interview or focus group discussions or case-study approaches (for a recent review, see Buus et al., 2021). These have explored the impact of the Open Dialogue approach on mental healthcare practitioners, clients and networks. For example, studies of patient experience and outcomes found that Open Dialogue helped patients to feel heard and supported (Jacobsen et al., 2018; Bergström et al., 2019; Suntharajah et al., 2022) and improved social functioning and quality of life by standard measures (Kinane et al., 2022). Studies of treatment sessions showed that dialogue which allowed clients to dominate and involved symbolic (rather than pragmatic) language was associated with good outcomes from psychotic crisis (Seikkula, 2007). In other studies, the success of Open Dialogue as a treatment was found to rest on family involvement promoting open communication, shared decision-making and a strong therapeutic alliance between family members

and mental health professionals (Eassom et al., 2014, cited in Jacobsen et al., 2021; Kinane et al., 2022). Participatory studies have used workshops and co-created interview guides to produce insights on the transformative effects of Open Dialogue for practitioners, clients and networks (Jones, 2019; Tribe et al., 2019).

Such studies have largely focused on dialogical intervention in relation to measured outcomes, with less focus on the complex processes of implementation based on in-depth, long-term ethnographic data. Methodologically, the literature includes detailed and contextualized case studies combining clinical records, selected observations and interviews (e.g., Buus and McCloughen, 2022), but these have not used immersive participant observation.

To our knowledge, the only ethnographic studies that exist, undertaken by anthropologists trained and embedded in OD teams, are those included in the Parachute project in New York (Pope and Parachute, 2015; Pope et al., 2016; Cubellis, 2018; Hooper et al., 2020), work on Open Dialogue in crisis intervention teams in Berlin Olson's (2015) and Cubellis (2022) auto-ethnographic account of the experience of Open Dialogue. Additionally, a non-participating ethnographic study in Australia focused on a private, inpatient young-adult mental health unit (Dawson et al., 2021) and an anthropological study was undertaken on staff training and team meetings in the feasibility stage of the above-mentioned UK Open Dialogue trial (Wright, 2022, in press).

What can ethnography contribute to research on Open Dialogue and why might this be important, alongside other kinds of evidence such as from RCTs? As Csordas (2021) puts it, while psychiatric and psychological studies determine *treatment efficacy*, ethnography aims to understand *treatment experience;* and while the production of evidence on efficiency focuses on the procedures and outcomes of treatment, ethnography focuses on what lies between procedure and outcome, namely therapeutic process as "the intersubjective locus of healing." So through ethnography's descriptive practice we understand the unfolding process of dialogical encounters, meaning generation among participants, and articulation with wider social and institutional structures (Csordas, 2021; Cubellis et al., 2021, 2033; e.g., Olson, 2015). The inductive approach means that we discover (rather than know in advance) what questions need to be asked about Open Dialogue; questions such as, how variable are the processes of dialogue, how readily do people draw in members of social networks, how does the intervention end, what is an outcome, what is the role of medication, how are specialist therapies included?

Ethnography aims to discover the social/institutional conditions of Open Dialogue practice: what aspects of a health system interrupt dialogical practices, what pressures are placed on which staff? Dawson et al.'s (2021) ethnographic study describes the internal tensions (e.g., among different stakeholders) and external barriers (e.g., from insurance systems) involved in integrating OD into established forms of care, and the strain on staff working across systems. They record the effects of weak institutional support, blocking, and over time reversion to non-dialogical practice.

In their review of research on the implementation of Open Dialogue, Buus et al. (2021, 1,128) noted the general lack of such descriptions of the organizational contexts ("culture, resourcing, and management/leadership") and strategies for delivering Open Dialogue. But they also note that available studies emphasize the "indeterminacy" of Open Dialogue—the variability in its practice and organizational constraints. Such indeterminacy is a "challenge to implementation efforts that favor specific and standardized practices"—that is a high degree of "technicality" (Buus et al., 2021, 1,118). They therefore advocate "the development of implementation initiatives that theorize Open Dialogue practices with higher levels of technicality without corrupting the fundamental spirit of the approach" (*ibid*), on the grounds that this "might mitigate possible conflicts with existing approaches" (Buus et al., 2021, 1,130). This approach is demonstrated in recent work on "fidelity" concerned with "the extent to which an intervention is delivered as intended …and is of high quality" (Olson et al., 2014; Monjaras and Mauricio., 2019; Waters et al., 2021, 806).

Ethnographic inquiry into Open Dialogue is interested in both the technical specification of the model (policy or protocol) and its relationship to actual practice. But anthropologists of policy are skeptical of the idea of implementation insofar as this implies application or delivery of a model, placing the technical design at the center of the unfolding drama. Nothing is simply *implemented*; on the contrary, for anything to happen, policy designs must be translated into the diverse interests, meanings, and motivations of the actors that a program brings together. The idea of "translation" here is from Latour (1996, 2005). It implies that models or protocols are necessarily transformed as they become part of people's interests, tactics or ambitions. And because the people and interests enrolled in the delivery of Open Dialogue are diverse, the relationship between scheme and practice is invariably complex, however precisely specified technically. There is necessarily a gap between policy and practice, because practice has to be determined by the interests, relationships and exigencies of given environments. We have to discover the personal and organizational agendas that are, or fail to be, connected to Open Dialogue, and how OD creates and mobilizes interests so as to be sustained (*cf.*, Latour, 1996, 86). The additional matter is that actors involved often have an interest in representing their actions in terms of the authorized model, which offers an interpretation of success (or failure); there may be reasons to hide the mess of practice behind the language of policy (*cf.* Mosse, 2005).

Ethnography pays attention to such processes. Examining this "loose coupling" of policy and organizational practices (Rottenburg, 2009), the necessary adaptation, improvisation, reinvention involved in translation, is a means to discover ways to make OD work or improve. As Cubellis et al. put it, ethnographic approaches can be

> "understood as strengthening the internal (connection between intervention and outcome) and external (understanding of the interrelation of context and outcome) validities as well as the translational impact of an intervention (Pfaff et al., 2017)" (2021, 2031)

Practically, embedded researchers can provide on-the-ground feedback, using ethnographic skills "to convert the 'noise' of actual implementation processes into information with instructive power" (Pope et al., 2016, 508), and potentially foster organizational capacities for learning.

Ethnographic studies of OD use experience-close description to explore and reconceptualize aspects of practice to bring new insights. For example, from her study in Berlin, Cubellis (2022) has shown the inadequacy of conventional ideas of mental health outcomes focused on individuals' symptom reduction and quality of life to account for processes in Open Dialogue. Instead, she explains (good) outcomes in

relational terms as a matter of change in the distribution of responsibility in a family and social network. The role of medication is also thrown into a different light, in one case study, as serving in part to manage the dangers posed by family history. The ethnographic insight that medication is a "technology for distributing risk" (Cubellis, 2022, 85) allows a new way of thinking about risk and the relationship between interventions and effects.

Another ethnographic study, listening to team reflections in an Open Dialogue service in the NHS, reveals the dilemma of "temporality" (Wright, 2022). The issue is that members of the team are committed to a slowed-down dialogical way of working, but are themselves desperately short of the time necessary to work in this way because they function in a healthcare system that is itself in chronic crisis (Wright, 2022, 317, 326). This brings out the constant effort required to work in a different temporality, and how healthcare is unstable and precarious. The analysis here allows deeper thought about what is understood by crisis. Seeing crisis as a matter of time reveals an intersection of individual and institutional crises.

In both these ethnographic studies, Open Dialogue is described in its affective and ethical dimensions both for practitioners and in the experience of family networks They also use social theory and comparison across fields to place particular events in Open Dialogue in a wider context of institutional and political processes.

To offer critical insight, it is necessary for ethnographic research to examine what happens in Open Dialogue in terms that are not restricted to those provided by OD itself; to stand outside its discourse that frames, explains or judges experiences and effects, so as to see self-validating blind spots (Davies, 2019): in short, to make the Open Dialogue model the object of inquiry. This means asking what Open Dialogue means to staff or service users. We want to know how the transmitted model, the skills and values have effects on behavior and its representation, on expectations, relationships and the sense of self of practitioners. But we can also ask, when is Open Dialogue a salient organizing idea or frame of reference for different actors, and when is it not? After all, clients vary in their perception of the treatment they receive as Open Dialogue and they may understand what the term means differently to clinicians (as we are discovering in ongoing research). While an RCT relies on the fixing together of practices so that Open Dialogue becomes a coherent thing, to allow comparison with regular treatment, for anthropologists whether or how OD is a stable set of ideas and practices is an empirical question. Anthropological research identifies the narratives of Open Dialogue, their genealogy, and their stability or instability in different institutional contexts (*cf.* Lovell et al., 2019). As a culturally comparative discipline, anthropology places particular ethnographic accounts of OD in the context of cross-regional studies, thereby pluralizing OD, considering local adaptations, the political economy of different healthcare systems, what knowledge or moral frameworks are involved, and what allows or inhibits the circulation of the approach. Tracing the interconnecting threads across sites and contexts enables a view of OD as an emerging network, a social movement for person-centered and rights-based change in mental healthcare, inserted within the embracing framework of Global Mental Health (e.g., WHO, 2021).

Anthropology brings to the table a critical (and self-critical) orientation towards research itself; awareness of how power influences the production of knowledge. This dovetails with service user and survivor efforts in recent years to contest dominant psychiatric knowledge (Rose, 2017). Ethnography allows juxtaposition of a plurality of knowledge forms to include those of service users, activists as well as professionals in the NHS. In the study to which we now turn, the trial (and participation in its conduct) is not only the context, but also the object of critical enquiry. However our purpose is not a social science critique of RCTs (Smith-Morris et al., 2014; Adams, 2016; Deaton and Cartwright, 2018), but to bring a critical and contextualized approach to knowledge production of a clinical trial of OD, with the goal of yielding complementary insights that help interpret and apply findings.

While Open Dialogue as the object of inquiry is re-framed in anthropological terms, this object itself shapes and changes the motivations and methods of the ethnographers involved (Mosse, in press). Perhaps anthropology is unique among social sciences in opening its methodology to the knowledge practices of its subjects of inquiry. The ethnographic focus is on knowing the world in the manner in which our subjects know it; not just knowing about them. Ethnographically, perhaps we are not so much learning *about* people's lives and worlds, not mapping out, but *taking in* "from a particular vantage point" (Ingold, 2011, 237; Mosse, in press). This interplay of method and subject of enquiry is not found in other disciplines.

An anthropological study of Peer-Supported Open Dialogue

The study whose methods we report here further explores the potential of ethnographic research in relation to Open Dialogue. It has been set up to run in parallel with the large UK NIHR-funded research program "Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness" (ODDESSI) and its three-year multi-site RCT (Pilling et al., 2022), running (with Covid interruption) from 2019 to 2023. This trial pilots a variant of OD that includes service-users within multidisciplinary practitioner teams (Peer-supported OD or POD) across five Mental Health NHS Trusts (Razzaque and Stockmann, 2016).

The RCT will tell us whether on average people in crisis receiving OD do better than those in treatment as usual, drawing aggregate causal inferences.[1] But the trial will not explain how or for whom OD may work, or what human and contextual factors (that is, the sets of social and institutional relationships) influence the practice and effects of OD, nor will it be able to distinguish factors inherent to the therapeutic approach from those contingent on a given locality, client population, clinician group and health service upon which the observed causal effects depend. It is here that our ethnographic study (APOD) makes a contribution through its ground-level description. It also uses oral history and archival research to contextualize the

1 The ODDESSI trial quantifies effectiveness in terms of a primary outcome—time to relapse following recovery (relapse being "the return of significant symptoms and deterioration of social functioning"), and secondary outcomes such as time to "user-defined recovery," service user satisfaction and quality of life. It produces data on potential mediators (e.g., measures of social network, shared decision-making) and family/carer outcomes (Pilling et al., 2022, 3).

innovation in time. It allows us to identify *pre-existing* aspects of what we now know as Open Dialogue (e.g., client-centered work, polyphony in decision-making) which might otherwise falsely be interpreted as system-immanent phenomena when they recur in other policy forms.

To be clear, the aim of the ethnographic study is not evaluative. The question is not, "does this approach work?" but rather "what happened?" "how did it happen?" "what changed?" "what did people make of it?" "what did it feel like?"[2] The study is able to expose the process, such as what is going on in dialogical encounters with clients and within the team, including the effect of different voices in meaning-making. While the ethnography is not focused on *proving*, it is concerned with *improving* (Mol, 2006). In other words, while it does not aim to prove the efficacy of an intervention through generalizations, it does provide knowledge that is necessary to generalize interventions in practice. If positive RCT outcome data lead to widespread adoption of Open Dialogue (in the UK or elsewhere), ethnography's inductive and holistic study of particular contexts and client populations will be important in setting out factors relevant to implementation that cannot otherwise be known in advance. If OD is *not* found to improve outcomes in clinical trials, this knowledge is equally (if not more) important to discovering the salient explanatory factors.

Preceded by 18 months preparation to test this use of ethnographic methods, to secure work contracts and ethical clearance (and accommodating Covid-19 interruptions), the study is undertaken over a 3-year period (coinciding with the RCT).[3] It involves researchers situated inside local NHS mental health trusts implementing the POD model (from 2019) as formalized through training, defined organizational practices, operational procedures, fidelity criteria and adherence measures and manuals. It has two contrasting UK locations: one in a highly diverse inner-London borough where 180 different languages are spoken, the other a majority white British coastal area in western England. Both sites have high levels of intersecting disadvantage, inequality and social marginality of different kinds contributing to mental health crises. The POD teams where ethnographers practice and research are found within local community mental health teams (CMHTs) allied with crisis and home treatment teams (CRHTT), in-patient wards, and early intervention psychosis service (EIS) teams within secondary public mental healthcare.

The POD teams include POD-trained psychiatrists, psychologists, nurses, social workers, occupational therapists, managers, peer-support workers (and anthropologists). They sit within wider multi-disciplinary CMHTs serving a total client group at any one time of anywhere between 500 and 700 people, and up to 240 people in the case of the Early Intervention Psychosis service (EIS) in London. The two POD teams included in this study work with people in crisis (according to the UK Mental Health Triage Scale) referred from randomized GP "clusters." These clients are joined by any family/social network members they want with them in the "network meetings" that are held with trained POD practitioners. As part of the wider RCT, all recruits are followed up for 2 years.

The ethnographic study involves a team of three anthropologists who for the purposes of the study trained in POD and work alongside NHS clinicians. At the same time, three others, already experienced POD practitioners—a consultant psychiatrist, a clinical psychologist, and peer/family therapist—were trained in ethnographic methods. Three members of the team identify as "peer" or carer POD practitioners with experience as mental health service users or immediate family members of those suffering serious mental illness or crisis. One of the anthropologists took up a part-time peer worker position, adding a further intersecting role. The capacity of the team was later augmented by *in-situ* POD practitioners trained as ethnographic research assistants.

All of the researchers are full members of POD teams. As such, researchers attend all clinical, reflective practice and business meetings; they practice the mindfulness encouraged by the model and acquire a case-load of POD client networks in which they are lead or co-practitioners. All POD team members in both sites consented to participant observation (49 staff including ourselves) as did a larger number of trainers, advocates and managers involved in the study. Across our two sites (inner-London and west England), 30 of the client networks—in CMH or Early Intervention Psychosis services – consented to the ethnographic study, most but not all of which are in the ODDESSI trial.[4] They have agreed to our participant observation (and sometimes recording) of meetings.

The research participants in our study are therefore all of our POD team colleagues, and all clients and family members with whom we interact, who have consented to our keeping journal notes/records (hand written or typed and anonymized) on staff meetings, 'intervisions' (see below) and POD network meetings. Given that the six-person team participated in several staff and/or client meetings daily over a 2-year (and for some 3-year) period the number of journal entries and fieldnotes will run into thousands (and a much smaller number—under 10—recorded network meetings). We might for example have notes on as many as 40–50 meetings with a particular POD client network who we meet every few weeks over 2–3 years; with shorter duration more infrequently met POD clients, the number will be much smaller. In the first instance these records are indexed and coded by researchers individually, prior to collaborative analysis for varied outputs. In addition to researcher fieldnotes, staff and clients (2 people) are keeping reflective journals, and one client a video diary.

So far, we have also held in-depth interviews with 29 network members (clients and family/friends) across both sites, and individual/group interviews with 61 staff local to our field sites and 31 from a wider range of POD trainers, researchers, policymakers and advocates (as of November 2022). These interviews lasting 1–2 h have topic guides but are open-ended to allow expression of thoughts and experiences of staff and clients and their context. The recorded

2 We might be tempted to ask *why* Open Dialogue works, but this implies the impossible question: why is a person mentally ill, why do they get better? We do not know how illnesses or therapeutic processes work, only that they seem to.

3 Ethnographic research of this kind is unobtrusive and involves the expected rigorous consent, confidentiality and data management procedures. Given that health research governance is still set up as if all research is like a clinical trial, explanation of recruitment and sample size can be challenging.

4 Most of these 30 networks in the ethnographic study are also part of the ODDESSI study which recruited, respectively, 37 and 60 participants to the inner-London and west England sites of the POD arm of the trial.

interviews are transcribed and securely stored for individual and joint/team coding and analysis.

This is an extended clinical ethnography by "complete member researchers" (Anderson, 2006, 379–82) with different viewpoints: long-term organizational insiders, those bringing lived experience, and anthropologists with the observational stance of the "professional stranger" (Agar, 1996). As implementors of a trial, the team has a professional duty to adhere to the POD model in which we are trained, while having a personally motivated ethical commitment to bring improvement to psychiatric care (*cf.* Lester, 2019, xxi). But the study has social scientific objectives, is charged with maintaining analytical independence, and is separately funded by the UK's Economic and Social Research Council.

The research is structured around three aspects of POD, each with distinct ethnographic "fields" and key questions. These are, POD as: (1) a dialogical model of treatment, studied in clinical encounters, asking how are OD principles translated into practice? (2) a social network approach, studied in specific communities, asking what is the link between what happens in therapeutic settings and in the social networks of everyday life in city and small-town localities? and (3) a way of organizing mental health services, studied in institutional systems, asking what are the historical antecedents and organizational requirements of OD?

For POD as a dialogical model of treatment, the sites of study are POD trainings, the reflective practice of team meetings and weekly "intervisions" (see below), and the therapeutic practices, especially the network meetings where clients and any members of their social network they wish to involve (family, friends, key workers) meet with a minimum of two clinicians for open-ended conversations. These are initiated after a mental health crisis, and occur at various intervals in response to need, in homes, hospital meeting rooms, via phone or online video calls, and over periods from 2 months to over 2 years.

Since we apply our clinical training as practitioners in field research, POD is the *means* as well as the object of ethnography. Relationships with clients and colleagues are governed by principles of presence and open attention rather than questioning and interpretation (as other ethnography often is). While POD practitioner and ethnographer identities merge, research practices are kept separate. Observational and self-reflexive data take the form of field notes and recordings written and analyzed outside and time-removed from the clinical context, so it is clear that this is *research* data that does *not* "support measures or decisions with respect to particular individuals" (UK Data Protection Act 1998). As both practitioners and ethnographers we have to be "vigilant about [our] motivations" and responsibilities in a complex double task; and if clinical and ethnographic roles are in conflict, clinical roles take precedence (*cf.* Lester, 2019, xxi). This means there are clients and situations where we are involved as POD practitioners but have not felt it appropriate to follow up consent for research participation observation.

As ethnographers, where colleagues and clients have consented, after meetings we record as much as possible about our subjective experience of what took place; this may include observations on the different styles of interaction, speech forms and symbolic practices the use of humor, what we see of the interplay of power and identities (of gender, age, race, language), conflict and the emotional quality of the dialogue of all in the network (including relationships among practitioners). Occasionally, we have audio-recordings to draw on. We come to learn what dialogical meaning-making actually entails, what encourages or inhibits this in sessions, and how practice varies with different clients, or is adapted to accommodate distinctive cultural ideas or expectations of illness, treatment and recovery. We begin to address recurring questions such as: when is dialogue difficult? why are many clients unable to bring others to meetings? how do diagnoses and medication enter the dialogue? how do we as clinicians use "disclosure" of personal experience; how do network meetings change over time, and what adaptations did Covid-19 bring?

Folded into network meetings are other routine practices such as medical reviews, diagnostic or self-harm risk assessments and safety planning, all dialogically adapted. Participant observation also involves encounters with clients and colleagues beyond protected POD spaces of home or consultation room. We join our clients in their psychiatric assessments, in "ward rounds" on locked psychiatric units, in seclusion or in prison, during Mental Health Act assessments, in mental health tribunals, with the Crisis Teams, and in the processes of the government's counter-terrorism Prevent strategy, among others. In these non-dialogical contexts our role, where we can, is to introduce or negotiate a dialogical way of working. We find ourselves being advocate-observers of POD fidelity criteria, such as "no discussion about clients in their absence," but also reluctant participants in their breach.

Over time, our encounters with clients are broadened through one-to-one meetings (less favored by the model, but common practice for those of us with "peer" roles), in parks or cafés, on walks, while playing board games, joining creative projects (e.g., film-making), or pursuing solutions to their practical needs in relation to housing, the asylum system, or connecting to community-activities (music, sport or gardening). Through these dialogues, as POD practitioners and peer workers we learn about the context of people's lives and their use of mental health services, their life circumstances (being a migrant or asylum seeker, drug use, homelessness…), the importance of family relationships, loneliness, sexual abuse and domestic violence, and the powerful effects of race, religion or gender, as well as extraordinary endurance, insightfulness and creativity. We are privileged to be able to develop richly woven and carefully anonymized case studies, which need literary skill to convey.

Extended ethnographic interviews with clients having received POD for lengthy periods of time, allow them to reflect on their experience and express opinions, including to each other when brought together for group discussions. People can also express themselves directly and in their own voice through keeping reflective journals or video diaries. As we approach the end of empirical research, use of other client-led media of expression are planned in order to convey the journey with POD in creative and artistic ways: client-led films, dance, zines or music.

The deepened collaboration with clients whom we remain in contact with beyond as well as through clinical encounters, and sometimes after they are discharged from the service, contributes to the second aspect of POD, namely as a social network approach. The question here is, what is the link between what happens in therapeutic settings and in the social networks of everyday life in particular localities? We approach this question through our participant observation extended to the long term, periodic post-discharge interviews and holding drop-in feedback sessions in community settings.

However, given the extremely attenuated nature of most of our clients' networks, that many are isolated or painfully lonely, it has proven a challenge to study (as originally intended) how social networks contribute to and are changed by the POD process. We wanted to trace family and

community histories and map social connections in the locality and therefore to trace how professional care and community social networks intersect. But for varied reasons, many clients find it difficult to invite family or others to the network meetings, even though the dialogue there often revolves around difficult relationships with significant or lost others who are thus powerfully but invisibly present. Sometimes, the POD team has become a client's network, especially under conditions of Covid-19 lockdown; or we link together a network of key workers from other services.

Although in some cases we are able to trace links between POD practices and wider associations in the neighborhood, many times we witness continued struggles to find connection. Certainly, we are able to investigate the various ways that POD may or may not foster capacity for social connection or social re-entry in recovery. At least this ethnographic approach to the "fluid pathways that individuals and their social networks follow in response to illness" (Perry et al. 2015) will offer a richer multi-stranded complement to quantitative social network outcome data (e.g., self-report Lubben Social Network Scale) gathered through the ODDESSI trial.

The third aspect of POD under investigation, as a way of organizing mental healthcare, focuses on the institutional system. Our means to address the question of the organizational requirements of POD is as members of clinical teams with access to the everyday practical and emotional life of mental health work over an extended period that has included significant institutional change. First, there was the adaptation to Covid-19 in 2020–21, and second the disruptive reorganization brought by the UK's national Community Mental Health Transformation Framework (still underway in 2022), which is creating or closing-off space for Open Dialogue in ways that need investigation. As contracted members of NHS teams we are subject to the clinical governance and bureaucratic systems that we observe, and accountable for following documentation and other procedures.

We experience the pervading pressures and anxieties of working in statutory mental health care, and the particular difficulties in accommodating and sustaining POD teams within existing community mental health services. Participant observation affords opportunity to see organizational processes around POD in real time, while ethnographic interviews across the whole team (and beyond) capture and elaborate staff reflections on this. Staff interviews place the views on POD in the context of career paths in diverse mental health teams, and expectations, hopes or frustrations in relation to POD.

Para-ethnography, auto-ethnography, and institutional ethnography

Ethnographic research on POD is helped by the approach's own reflexive practices that might be called "para-ethnographic spaces" (Holmes and Marcus, 2006) contributing ethnographic insight on the conditions and experience of Open Dialogue in the NHS. Principal among these are the weekly reflective practice "intervisions." These are two-hour long structured meetings involving the whole team using a similar dialogical model as the network meetings with clients—face to face until late-March 2020, thereafter mostly online or "hybrid" online/in-person.

Each week, team members are encouraged to reflect on concerns and dilemmas from work with clients without bringing the "content" of a particular client/network's circumstances, or offering interpretation and formulation. This distinguishes intervision from usual case review meetings. As well as grasping the process, as researchers through intervisions we can identify dilemmas of POD practice and the feelings, thoughts and images that arise and are the focus of this structured dialogical team practice. Through repeated sessions over 2 years, we are able systematically to outline the relational and emotional qualities of POD practice, including the complex range of feelings towards clients: compassion and its failure, empathy, aversion, guilt, anxiety "that enters every cell in your body"; and to turn over the complex notion of love in a mental health service. Team members have space to be heard and to process their own feelings such as understanding "why I shut down with X," "my feeling of rage towards Y." There is space to explore such countertransference and its experience in the body, alongside failures of confidence, the complex burdens of responsibility, (self-)judgment, rescue fantasies, and the all-too-common exhaustion and burnout.

Intervision also entails dialogue on relationships with colleagues, including tensions and disagreements that throw light on professional identities, status hierarchies, mutual protection and judgment, performance anxiety or power imbalance in the emotional labor of POD, and the question of who speaks and who feels silenced. Through "self-work" exercises, there is invitation to staff to talk about things on the boundary between the personal and the professional that hone our clinical work, including family background, values or faith, responses to which highlight whether and for whom such POD spaces are experienced as contained or safe [see Wright (in press)]. These sessions allow refinement of dialogical skills, and reinforce POD principles ("do not bring in 'content,'" "name your emotions"). Sometimes the power of words or metaphors, and the delicate uncertain boundaries around POD practice, are revealed in the mis-spoken comment, the overwhelm of emotion.

Practitioner exchanges in meetings and intervisions are how the dilemmas of POD practice are surfaced, such as the tendency to work with lone (and lonely) clients without family or other networks, uncertainty about endings and the question of whether POD should be a form of ongoing therapy rather than primarily a response to crisis. There are repeating questions about diagnosis and medication, and the interface with other (non-POD) teams and approaches, and the handling of people who are at risk of suicide (which also reveals different judgments and feelings of responsibility in a team, such as between psychiatrists, nurses, or peer workers: who makes the assessment, who carries the anxiety?). Team members at times air their criticism, skepticism and frustration around POD, its fidelity criteria and the intersection with the exigencies of standard service delivery and clinical governance, as POD is buffeted by the pressure of caseloads or Key Performance Indicators and demands for patient "flow" through the system, staff turnover, disrupted leadership and teams diminished by wider changes in the mental health services.

There is much to learn about clients' and colleagues' experience of POD, including in its imperfect hybrid and improvised form, and its effects as often reported by clients. Of course, much of what we do as actors within the clinical system is not dialogical but administrative, focused on meeting the demands of record-keeping and other protocols, and everyday interactions in the office, travel to clients' homes, team check-ins, office celebrations or training events and away days, all of which fall within ethnography's commitment to methodological holism.

With Covid, the virtual online space and its challenges became an important aspect of our experience in the service. Working online significantly changed interactions with clients and involved additional uncertainty around sensing the state of a person. In one team, there was concern that lockdowns fostered an apparent engagement divide between people with "psychosis-type" problems (who risked dropping out) and others who were more willing to meet online. This occurred alongside other adaptations, disruptions, redeployments, depletions and opportunities that the pandemic brought.

In this study, researchers are not invisible observers (*cf.* Anderson, 2006, 384) but provide first-person accounts, paying attention to documenting their subjective experience and the way POD structures personal and professional lives. This means it has an "auto-ethnographic" element. Auto-ethnography involves "connecting the self to the social" (Taber, 2010, 9; which distinguishes it from biography), exploring the social conditions of our own thoughts, feelings and actions (Ellis et al., 2011). We consider the personal impact of POD's affective labor, including its unsettling aspects such as doubt or anxiety (Cook, 2020, 190–91).

This project allows multiplication of accounts of ourselves as institutional actors holding different positions in the healthcare system. Working alongside people in other roles—nurses, social workers, managers—we expand and systematize the documentation of POD as lived in organizations. This is what Anderson (2006) categorizes as "analytical autoethnography" or more specifically it is "organizational auto-ethnography" (Herrmann, 2020); that is involving descriptive accounts of our roles in the NHS mental healthcare organization directed towards a systematic documentation of POD in this bureaucratic setting.

Undertaking ethnography through a group of researchers is unusual, but it allows both extension over multiple sites and recording experiences of POD (even of the same events) from different subject and disciplinary positions. The study can aim for dialogue in its analysis and interpretation too, so as to retain the multiplicity of voices without losing analytical coherence (see below). Working in a highly complex organizational setting (NHS healthcare) makes such a collaborative approach particularly useful [see Lapadat (2017) on collaborative autoethnography; and Sambrook and Doloriert (2020)'s model of collaborative organizational autoethnography].

Our research begins with the everyday and the autoethnographic, but exploring how POD is (co)produced and experienced (by practitioners and clients) requires explicit focus on organizational policy, decision-making, and analysis of the texts and graphics (participant-informed discourse analysis) and those powerful representations that organize experience, direct attention, shape people's narratives, and appear to tie people and events together—that is "institutional ethnography" (Smith, 2005; Taber, 2010; Chapman et al., 2016). Spreadsheets and budget lines, staffing plans, training budgets all delineate organizational commitments. Looking at institutional policy in this way necessarily has a historical dimension. After all, there are those staff with 20–30 years' experience of frontline work, who say POD is just the latest in a long line of similar policy innovations that failed to effect system change; and the same can go for service users and carers.

The APOD study uses a combination of archival materials and an oral history approach to examine antecedents of POD in community psychiatry since de-institutionalization (Leff et al., 2000). Oral history shares with ethnography an intersubjective process of meaning-making while serving to interpret and qualify other types of sources. Oral history is itself juxtaposed with written records, printed materials, photos, pictures, objects of material culture and other sources. Like ethnography, the historical work is an inductive process mediated by the choices of the researcher. Themes and patterns are identified in the intersubjective process of the interview, which then can be applied to interpret other sources or vice versa. This circular process lends itself to collaboration and teamwork. The themes identified by anthropological questioning can also be applied as lines of inquiry when interpreting historical sources and can inform historical interviews.

Dilemmas, challenges, and opportunities

An ethnographic study of Open Dialogue of this kind brings challenges and opportunities, which we discuss under two headings: first, matters of research roles and relationships; and second, the relationship between ethnography and Open Dialogue.

Research roles and relationships

There is no doubt that the multi-tasking double labor of ethnographer-practitioner roles is demanding, cognitively, emotionally and in terms of time. Various expectations and responsibilities have to be balanced in relations with clinical colleagues, clients and team members. In terms of relations with POD team colleagues, the ethnographic study has been welcomed and all of our colleagues consented to research participant observation. Of course, this research method involved no interruption of everyday work. Indeed, since nothing marks us out in everyday practice, consciousness of our researcher roles fluctuates. Sometimes there is awareness of being observed, but more often it seems our colleagues forget we are researchers, which brings its own dilemmas. Rather than disruptive, the POD-trained anthropologists were a resource for highly stretched teams. It is true that researchers do not carry the heavy caseloads and responsibilities of others, and that our presence is transient; but as a sign of the endemic organizational change and staff turnover, in some teams the researchers are the longest-standing and most continuous of POD practitioners.

The other part of the research team, the clinicians who joined the study, valued the opportunity to devote time to keeping fieldnotes and conducting interviews as part of their POD practice. Ethnographic interviews with staff, mostly undertaken with those researchers have got to know well, were also valued as a space for informed and frank reflection, including with those who have for varied reasons left POD practice able to talk reflectively about their hopes and experiences from outside the POD bubble.

The study is supported by local teams as a means to document the realities of POD in practice in the NHS—the positives and the real-life difficulties experienced. There may be a few colleagues who are protective of the new POD initiative and fearful that too-honest description will identify failings that could be seized upon by senior manager skeptics and critics of POD. But it is often the ethnographers who are perceived as having privileged commitment to POD, our enthusiasm making demands on the resources of others that are not easily met. The imagined high expectations of researchers threaten the make-do compromises that hold an ordinary mental health team together, unbalancing the normal economy of energy that allows the "just keep going" of mental healthcare; or in other ways show-up, bring scrutiny or judgment to co-practitioners. At the same time, ethnographer-practitioners are a resource that allows a highly stretched POD team to function.

Regarding relationships with clients, we frequently grapple with the ethical question of how to safely encounter users of mental health services in changing roles—how to be both a practitioner and a researcher; a person directly involved in someone's care and a person, who steps back and interviews and interprets. Initially, our research roles had little immediate bearing on clinical relationships. Those who consented to the study welcomed it as an opportunity to contribute to an approach they regard positively, but our POD practice did not change. A few clients did not want to participate in the study, and some were too unwell to consent, in which cases we continued as non-researching POD practitioners. Some declined to participate in the ODDESSI trial but wanted to join the APOD study. As our project progresses there are more occasions when our relationships with clients *is* changed by our role outside of therapeutic contexts as researchers (and peer support workers). Even though POD deliberately softens the professional edges of conventional clinical practice, contact is still structured both by systems/rules and norms/expectations. So, when we become interviewers, for example, or collaborators in creative projects, we have boundaries to navigate.

The flexibility of roles and expectations is often positively experienced; but researchers are alert to risks that might arise. What happens, say, when our clients and interlocutors want to be our friends? The inequality and non-reciprocity of these relationships—in knowledge about each other—quickly becomes apparent. These are familiar conundrums for anthropological researchers, but when our interlocutors are mental health clients under the care of the NHS, the stakes are higher, and researchers have to exercise extreme care in the judgments made.

If the research confuses clinical roles, the demands as mental health professionals can threaten trusting relationships built in research, such as when the police are called for a welfare check, a Mental Health Act section is involved, or referrals to safeguarding. Of course, these are challenging for any POD practitioners not only researchers.

Peer practitioner-ethnographers find such role ambiguity and tensions amplified, especially where we are simultaneously expected to develop a different kind of relationship with clients than other staff, drawing on personal experience, but are misread or judged when doing so: perhaps being seen as too attached or vulnerable in relation to client distress, or advocating "too much" for a client. But then we all need to carry awareness of how our identity (gender, age, ethnicity, life history, etc.) influences our interactions, alliances and connections both as POD practitioners and ethnographers. We might, in an OD meeting be clinicians at one moment, women in solidarity with a victim of gender-based violence at another; or in another network allied as a member of a racialized minority.

Finally, we have to consider the relationships among ourselves as researchers and authors which has a large bearing on the conduct of the study, how data are produced and how writing and representations are negotiated. Inter-disciplinary collaborative ethnography of this kind adds "one more layer of intersubjectivity" (Chang, 2013, 111). As research team members, we interact with each other in different roles—as POD co-practitioners, members of mental health teams, and as researchers. In each role we navigate internal boundaries concerning what we share, and at what point the inner-dialogue, observations and reflections, become an outer dialogue of shared data and analysis. Of course, this is shaped by different roles and power in the team—research assistant, PhD researcher, supervisor, or collaborating co-investigator.

Ethnography and Open Dialogue

In this final section, we return to some of the opening comments on anthropological method and consider the complex relationship between Open Dialogue and anthropology. On the one hand, anthropology is an appropriate discipline through which to understand Open Dialogue due to a resemblance between the two. Both are concerned with the relational and intersubjective; attentive to the diversity of perspectives; to sense-making through dialogue, and focus on endogenous meaning and its generation rather than exogenous meaning and categorization (Razzaque and Stockmann, 2016, 353). Open Dialogue encourages that ethnographic stance of being unknowing guests collaborating with clients who are experts in their own experience, exploring each person's relational, inner and outer world, as a "unique *culture* with its own history, language, values, practices, symbolic systems…and dominant themes" (Lester, 2022); and thus "creat[ing] a new therapy for each client" and each network (*ibid*).

The POD training, focused of course on responding to crisis, was also a field methods training for ethnographers in the conditions of presence and attention at extraordinary moments, even providing tools to rate how dialogical we have been. In network meetings with clients, we learned to focus attention on words, phrases, sensations and emotions that arise in the moment, repeating back the phrases we hear, extensively using paralanguage (tone, pitch, "uums," "aahs," facial expressions…) and trying not to gather together interpretive threads for ourselves. We are enjoined to "listen to what people *say*, not what they mean" [Harry Goolishian 1924–1991, referenced in Heikkinen and Sutela (2009)]. Our style of ethnographic interviewing too has come to mirror Open Dialogue forms. Although of course (both as practitioners and ethnographers) we make choices regarding which utterances to respond to, which bodily sensations to pick up and verbalize, which thoughts to amplify through "reflections" and which inner thoughts to hold on to without saying them out loud.

On the other hand, ethnography is quite different from Open Dialogue in explicitly developing an interpretive stance. It remembers past statements and builds context around dialogue through theoretical and comparative framings, and creating and communicating a meta-narrative. Ethnographic note-taking itself is not dialogical. It occurs in a space apart and requires stepping back or stepping out of a situation so as to make it visible and understandable to by-standers not actively involved. In contrast, with Open Dialogue the shared meaning-making is open-ended and communicates itself immediately and often non-verbally to the participants in a sense of connectedness and feeling heard or feeling moved.

Ethnographic research of all kinds holds a tension between presence and interpretation, between maintaining relationships (here with mental health teams and clients) and practices of description which may objectify colleagues or clients. Writing is that which is premised on absence from encounters; it "turns away" (Ingold, 2011, 179). There is then an ethical ambivalence in turning dialogical encounters into interpretive production. However, through our writing we try to retain the dialogical and polyphonic in our texts; an interaction of different points of view that points to the shared dialogism of ethnography and Open Dialogue [see Mosse (in press); Strathern (1987), 19].

Studies such as ours encourage a range of representations and co-production, as mentioned. But the anthropological task of interpretation and recontextualization means that ethnographic texts may not always align with insider narratives (of practitioners) since the terms of description are not (only) those of the POD community (Strathern, 1987, 18). Analytical descriptions are produced through

the (re-)integration of researchers into academic communities and a drive to "hermeneutic integrity" and communication of evidence and arguments. Whether this is difficult depends on how the team balances its advocate and critical stances; the ethical commitment to OD principles and the task of providing critical-analytical commentary.

The final point, still framed as a question, is to what extent can ethnographic researchers (including ourselves) use Open Dialogue as a model for data production and analysis? Could ethnographic observations be recorded dialogically through a team-interactive process, striving for a polyphonic mode of analysis in order to encourage difference in interpretation, defer conclusions and avoid a master narrative [see Wells et al. (2021) for an example]?[5] This might at least provide a means to resolve any interpretive difference or impasse that arose in team-based collaborative ethnography (2021, 510).

These are posed as questions because, while it is likely that better understanding of a phenomenon will be gained by encouraging more voices, there are real challenges in making research properly dialogical and polyphonous. The APOD team have begun to set out the agreement "scaffolding" (Bennett and Gadlin, 2012, 6) for data sharing and output authorship, but there are many more questions. How is the ownership of ethnographic fieldnotes to be negotiated, particularly when they are on intimate and emotional encounters? What does it mean to have research outputs not only co-authored or coproduced, but polyvocal? How can client voices be integrated into academic research, not just encompassed as subject matter, or articulated in separate spaces? Participatory research is far from a new idea, but the representational challenges and contradictions are not easily resolved, given inequalities of power, voice and vulnerability between researchers and the researched, however much this categorical boundary is blurred (Rose, 2017; Rose and Kalathil, 2019; Williams et al., 2020).

Whilst there is no simple answer to these methodological and ethical dilemmas, the Open Dialogue principle of "tolerating uncertainty" helps to create a climate in which it is possible to keep open questions in the room when interacting with each other and users of services. How we remain loyal to this dialogical mode of ethnography in our writing and representations, and refuse to be arbiters of truth about Open Dialogue, still remains to be seen.

Conclusion

Anthropology has an important and distinctive contribution to research on innovation in mental healthcare such as Open Dialogue. Its core ethnographic method allows the tracking of complex activities and change in specific institutional and social contexts. While ethnography is not primarily aimed at evaluation or proving the effectiveness of an approach such as Open Dialogue, it makes an important contribution to improving the delivery and deployment of particular models of healthcare. Embedded practitioner-based ethnography helps understand the varied roles and complex agency through which the principles of Open Dialogue are practiced, and therefore how outcomes are necessarily the consequence of context as much as elements of design inherent in a healthcare model.

The article describes an anthropological research project allied to a randomized trial of Peer-supported Open Dialogue (POD). As a multi-disciplinary team-based study by trained POD practitioner-ethnographers, the project is a significant departure from existing research. It involves a method that can be both genuinely dialogical and participative, and in which Open Dialogue is both the object and method of research. But while being honed by the principles of Open Dialogue, this anthropological study involves critical, contextual and comparative analysis. The attention to treatment processes and institutional context can generate insights that are practically as well as theoretically relevant. The specific insights involved are not the subject of this article, which is concerned with methodology. The project's findings will be presented, and their implications discussed in future publications based on analysis of the ethnographic data.

Ethics statement

This study has received ethical approval from Wales 5- Research Ethics Committee (REC 20/WA/0037, 19/4/2020), and from the research ethics committee of SOAS University of London. All participants in ethnographic participant observation and interviews provide informed consent and sign a consent form, understanding that participant details will be made anonymous.

Author contributions

DM conceived and wrote the draft article and led design of the APOD project methodology and funding acquisition. LC, KP-B, and MW made editorial inputs. The article draws on a conference paper for the Royal Anthropological Institute's 'Mobilizing Methods in Medical Anthropology' Conference (18–21 January 2022), which DM drafted with contributions from RK, MC, and KW. DM, DB, MC, LC, RK, KW, and BC are actively involved in undertaking the research. All authors contributed to the article and approved the submitted version.

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5 Wells et al. experimented with use of a kind of open dialogue (structured process of listening and speaking, including reflective teams) to produce a team analysis of text. They maintain that through this dialogue (and counterpart 'inner dialogue' of participants) researchers became attentive to what personal life/values shape different motivations, ethics and epistemic positions and resistances, and of the intersubjective affect that bears on joint analysis. One participant says, 'When you speak and no one fills the ensuing silence, you are called to go a step further. When you listen and do not immediately respond, you become aware of the forces pushing you to respond' (Wells et al., 2021, 208).

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

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Development and refinement of the open dialog adherence protocol in complex mental health care

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Introduction: Open dialog (OD) is a both a therapeutic practice and a service delivery model that offers an integrated response to mental health care through mobilizing resources within the service user's family and community networks through joint network meetings. Therapist adherence is a crucial to the effective delivery of interventions. A key way to measure this is through structured observation tools.

Aims: The aim of this research project is to develop and refine the Dialogic Practice Adherence Scale, for use in OD research trials in the United Kingdom.

Methods: This study was a mixed methods approach to the development of an OD practitioner adherence measure. Initial steps involved meetings and discussions with experts and a review of the literature. Content validation studies were completed using a modified Delphi technique. To assess reliability of the measure, OD network meetings were audio-recorded, and tapes were rated by two independent researchers. Inter-rater reliability and internal consistency were assessed through quantitative approaches assessing variance.

Results: Results provide a description of how the OD Adherence Manual was developed in collaboration. Validation surveys showed high levels on consensus among experts in the field on the key elements of OD network meetings. Inter-rater reliability for the total score was excellent and internal consistency analyses suggest the scale is highly reliable.

Discussion: The scale presented here is an initial attempt at rating practitioner adherence in OD network meetings. It provides encouraging evidence that this can be done with strong validity and reliability and can be completed by a range of raters with varying levels of clinical experience.

KEYWORDS

open dialogue, mental health, adherence, reliability, protocol, measure

1. Introduction

At present in England, there is excessive pressure on psychiatric inpatient beds attributed to increased demand. This takes place in the context of reduced community resources, limitations in crisis response and decreasing availability of long-term community support (Wheeler et al., 2015). Individuals suffering from complex mental disorders, defined as emotional, cognitive, or behavioral disturbances that have reached a threshold that causes substantial functional impairment are most likely to be occupying these beds (Leichsenring and Rabung, 2008; Public Health England, 2018). These disorders have a long-term impact on the individual diagnosed and their support network and often require extensive interventions and multidisciplinary or multiagency team working (Horn, 1965; Keene, 2008).

Interventions that target the social network may have a role in ameliorating mental health crises, reducing the likelihood of relapse and therefore, help to decrease pressure on inpatient psychiatric beds (Hoult et al., 1983; Olivares et al., 2013). Although Community Recovery Home Treatment Teams (CRHTTs) often acknowledge and, may attempt to work with the social network of the person in crisis, the often-limited nature of CRHTT contact and poor coordination of services militates against this. Despite the early promise shown in randomized control trials (RCTs; Johnson et al., 2005) research suggests that CRHTTs may no longer be associated with a reduction in hospital admissions (Jacobs and Barrenho, 2011). This could be due to a considerable atrophy of the key functions of CRHTT with many services offering limited home visits outside of office hours and only 50% of services providing post-hospital discharge care (Wheeler et al., 2015).

Current service responses to these problems include the development of alternatives to admission (e.g., Crisis Houses; Lloyd-Evans et al., 2014), increased capacity for psychiatric assessment in Emergency Departments, and research aimed at improving CRHTT functioning [e.g., CORE program grant led by Johnson (2013)].[1] However, these initiatives focus primarily on the management of the crisis and its aftermath, not the wider system change (e.g., continuing community support) which needs to be addressed if bed pressures are to be reduced and outcomes for service users improved in the longer term.

Epidemiological research implicates poor social networks in both the development and maintenance of mental disorder (Giacco et al., 2012). Interventions which target the social network have been advocated by developers of crisis services (e.g., Hoult in London in the 2000s) but given the brief nature of CRHTT contacts, limited staff knowledge and skills, and lack of continuity of care, such interventions are not currently provided. In addition, the evidence describing the content of these interventions, and how services which deliver them may be provided by the NHS is limited. One such model which may provide an alternative approach to crisis care is open dialog (OD). This approach explicitly focuses on bringing about change in the social network while supporting an individual through a mental health crisis. In depth exploration of the content of this approach is required for its potential implementation into the NHS.

Developed in Finland, OD is a both a therapeutic practice and a service delivery model. It offers an integrated response to mental health care with an emphasis on mobilizing resources within the service user's family and community networks through joint network meetings (Seikkula et al., 2006, 2011). Network meetings are the core therapeutic intervention within the OD approach and often take place in service users own homes. In these network meetings, service users and their networks engage in shared decision making with professionals to deploy appropriate interventions (psychological, pharmaceutical, and/or social) with the aim of developing longer term mutual support. The development of an integrated OD approach to the provision of mental health services offers the possibility of an effective alternative to the current functional model where particular functions (e.g., crisis interventions, longer–term community support) are provided by separate teams.

A systematic review by Freeman et al. (2019) found 23 studies of OD (mixed methods, qualitative, and quantitative). The review suggests that although findings of these studies have been promising the evidence is low quality and RCTs are needed to draw any additional conclusions. Uncontrolled studies report reductions in bed usage and improved recovery rates following OD interventions (Seikkula et al., 2011). Although promising, there is no high-quality evidence to support an NHS-wide adoption of this model. In order to determine whether OD is an effective alternative to the current model, the ODDESSI program grant will undertake a multisite randomized control trial (RCT) comparing OD with treatment as usual (TAU). Findings from this RCT will influence whether or not changes are made more globally to NHS service structure to include more social network approaches. An important part of this research involves understanding what takes place in OD network meetings and how this links to therapeutic change.

The central component of an OD network meeting is a dialogic interaction, in which the basic feature is that each participant feels heard and responded to. Being an OD practitioner involves being able to listen and adapt to the particular context and language of every exchange and it is not possible to make specific recommendations for sessions in advance (Olson et al., 2014). However, there are distinct elements on the part of the therapists that generate the flow of dialog which in turn helps to mobilize the resources of the person at the center of the network (Olson et al., 2014). As set out in *The Key Elements of Dialogic Practice in OD* (Olson et al., 2014), there are 12 key elements or "fidelity criteria" of dialogic practice which are important for understanding the OD model (presented in Figure 1). These elements describe ways in which the practitioners can use utterances to generate new narratives amongst network members and move away from problem saturated interactions.

1 https://www.ucl.ac.uk/core-study

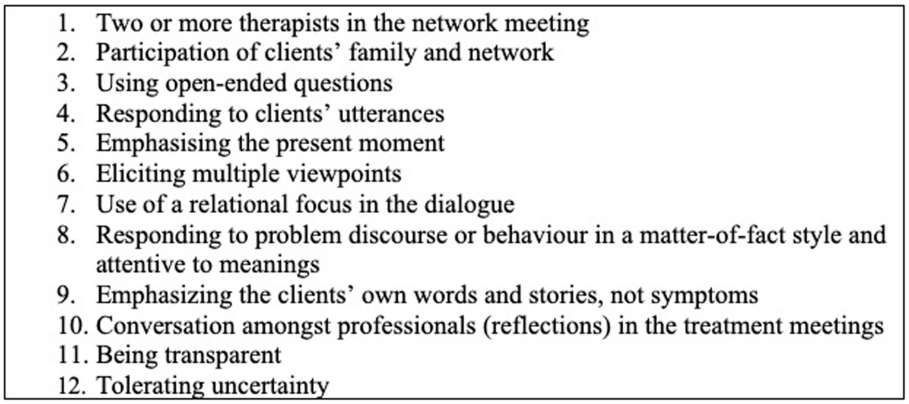

FIGURE 1
Key elements of dialogic paractice (Olson et al., 2014).

In order to ensure adequate implementation of the OD model, measures of treatment integrity such as adherence and fidelity are required. These measures will provide information to researchers and treating teams about whether or not the OD approach is being delivered as developed and intended. This is necessary to link treatment to outcome which is the wider goal of the ODDESSI RCT. The Key Elements listed above may be a useful starting point for the development of a measure of practitioner adherence within OD network meetings as they have been identified by experts in the field as integral to the OD therapeutic process.

Therapist adherence is a crucial to the effective delivery of interventions, as well as necessary to support successful dissemination across settings (Startup et al., 2002; Lange et al., 2016). It is used to reflect the degree to which therapists employ interventions prescribed by a model or framework and avoid the use of proscribed interventions during their therapeutic exchanges with service-users (Yeaton and Sechrest, 1981; Waltz et al., 1993; Schoenwald et al., 2000). The principal way that adherence is measured is through structured observation scales – measures containing the key components of a model based on its theoretical constructs. These measures must be psychometrically robust in order to accurately measure adherence and be useful for ongoing research into the efficacy of an intervention (Glasgow et al., 2005; Gearing et al., 2011). Using these measures, treatment adherence research can provide information about the successes and failures in the delivery of a model linking symptom change with therapeutic progression based on specific intervention techniques (Startup and Shapiro, 1993; Hogue et al., 1998; Onwumere et al., 2009).

Adherence scales for OD have yet to be formally developed and tested (described below). They are required for use in the ODDESSI RCT to ensure accurate implementation of the model. A measure of practitioner adherence using the key elements described above will allow researchers to more clearly establish the content of OD network meetings, ensure its successful implementation, and link the therapeutic approach with outcomes.

The "Dialogic Practice Adherence Scale" (DPAS; Olson et al., n.d.), has been developed in the United States for their healthcare system based on expert knowledge and consensus. It is in its introductory phases and included only the 12 Key Elements and a rating scale. At present, it has not been evaluated, validated, nor has the measure been used in research trials which would subject it to rigorous reliability and validity testing. The measure requires additional development in order to determine its applicability for use in the ODDESSI research trial.

2. Aims

The aim of this research project is to develop and refine the DPAS (Olson et al., n.d.), for use in OD research trials in the United Kingdom (the ODDESSI program grant). The primary goal is to begin the process of psychometric formalization of a measure of OD practitioner adherence. This process will involve determining the essential components of the OD model, as defined by the OD Fidelity Criteria (Olson et al., 2014), developing a rating manual for the measure to allow it to be used by research staff throughout the project, and testing reliability and validity of the measure to determine its suitability for wider use.

3. Materials and methods

3.1. Design

This study is a mixed methods approach to the development of an OD practitioner adherence measure. Initial steps involved meetings and discussions with experts and a review of the literature to provide face validity. Content validation studies involved the use of surveys with results presented through narrative synthesis and summary statistics. To assess reliability of the measure, OD network meetings were audio-recorded, and tapes were rated by two independent researchers. Inter-rater reliability was assessed through quantitative approaches assessing variance.

3.2. Setting

Data for this study was drawn from the initial feasibility trial of the ODDESSI work program conducted out of University College London (UCL). This is part of the initial stages of the RCT which aims to examine the implementation of OD across different NHS trusts in England and compare outcomes to TAU. The main work for this study took place at UCL with network meeting data from North East London NHS Foundation Trust (NELFT), Kent and Medway NHS and Social Care Partnership Trust (KMPT), Barnett Enfield and Haringey NHS Trust (BEH) and Devon Partnership NHS Trust (DPT). Network meetings were recorded between September 2018 and April 2019 and rating took place between January and May 2019.

3.3. Therapist and patient participants

Teams established to deliver OD interventions in the above trusts participated in this research. All practitioners (psychiatrists, psychologists, social workers, nurses and peer support workers) were trained in the OD model and integrated into practicing OD teams. Clinicians had varying degrees of training in the model, some attending training in Finland to the level of being an OD trainer themselves or more trained in the United Kingdom in a one-year foundation training or three-year full training program. Practitioners obtained written consent from all service-user trial participants and their networks for meetings to be recorded and for these recordings to be used in this research.

Service users were included in the trial if they were 18 years and above and suffering from a mental health "crisis." Mental health "crisis" included anyone who meet criteria for referral to CRTs. There is some variability in the operational definition of "crisis" across trusts and therefore additional variability in participants presenting to services in different areas due to the makeup of the population in more rural versus urban areas. Service users were excluded from the trial if they had a primary diagnosis of dementia, primary diagnosis of a learning disability, or drug and/or alcohol misuse.

A network refers to anyone closely involved in the individual service-user's care. This includes family, friends, GPs, individual therapists, keyworkers, named nurses, members of outside agencies, etc. The service user is encouraged to identify who they would like to attend these meetings and is given the responsibility of extending these invitations on a meeting-by-meeting basis. Therefore, the make-up of each network meeting varies unpredictably in size and composition.

3.4. Raters

Five individuals were trained to use the measure and rate OD network meeting tapes. This included two highly trained OD practitioners who have a key role in the research trial and are involved in OD training in the United Kingdom (RR and MH), a research assistant (EW) who was involved in the research trial but does not have a background in clinical or OD work. And, finally, two trainee clinical psychologists (ML and MAM) who are not trained in the OD approach but were currently undertaking DClinPsy degrees at UCL. Raters with varying levels of background in OD were chosen in order to test whether the scale could be used by non-experts. Raters were kept blind to which practitioners were involved in the network meetings being rated, although this was not set as standard and some practitioners introduced themselves at the start of the recordings.

3.5. Survey participants

Individuals that attended the OD International Conference in London in 2018 were contacted *via* email to take part in an online survey. All individuals were actively researching or practicing OD and therefore had significant knowledge about the approach and various techniques applied in network meetings.

3.6. Procedures

3.6.1. Measure development

As a starting point, collaborators (ML, RR, and MH) met to discuss the DPAS (Olson et al., n.d.), a measure developed in the United States to measure OD adherence in network meetings. The DPAS was still in development and had not undergone any validity testing. It was used as a starting point or framework from which the research team aimed to simplify the coding process and test the protocol's reliability and validity. The first step in the process was determining the key elements of an OD network meeting using "The Key Elements of Dialogic Practice in OD: Fidelity Criteria" (Olson et al., 2014) which set out the key methods used by practitioners in OD network meetings (presented in Figure 1). These key elements were then operationalized into specific behaviors that would be witnessable to an observer. This involved debate between the collaborators (ML, RR, MH, and SP) and four drafts were produced and open to edits.

During this process researchers in the United States (Ziedonis, Small, and Larkin) were also developing an OD adherence rating manual based on the DPAS for use in their trials. This resulted in The Dialogic Practice Fidelity Rating Manual. The Dialogic Practice Fidelity Rating Manual comprised similar components to the items that were generated through the collaboration described above. It was in draft form with a more thorough description of the elements of OD than the initial DPAS with some guidance on the process of rating and scoring an OD network meeting. However, it had not undergone any validity testing and was not being regularly or widely used. Work shifted to editing and refining this measure through consultation and debate amongst collaborators to increase the ease of use and relevance to the United Kingdom trial. Refining took place across months with

multiple drafts edited by collaborators with expert knowledge of the model. This was followed by the UCL rater training and analyses of reliability and validity.

3.6.2. Rater training

Once the coding system was agreed upon and necessary revisions made, collaborators began a series of practice trials using the measure over a two-month period. Following familiarization with the manual, all five raters individually rating 30-min to one-hour segments of one videotaped and one audiotaped OD network meeting. Following each portion rated, raters would meet and discuss scoring and increase knowledge of OD specific techniques. During this process, each individual noted specific phrases and times within the sessions that presented confusion for discussion as a group. All raters were new to using the coding system, however two were highly trained in the model and able to answer any technical questions and aid in decision making.

Following training, the five raters listened to a complete audiotaped OD session and met to discuss the completed coding criteria. Results on the criteria were visually compared for similarities and differences amongst the raters. Differences were discussed and any conflicts addressed by group consensus. Overall, agreement was established based on these initial ratings through visual inspection of the coding sheets and average ratings across the 12 items.

3.6.3. Rating

Practitioners were asked to record their network meetings with consent from the service-user and any network members present. OD sessions from different stages of treatment were included except for initial introductory sessions. There were no additional criteria that had to be met for a recording to be included in reliability analyses and, for the purposes of these analyses, it was acceptable for multiple recordings to come from the same family and same practitioners. This was because, for this study, the focus was on the utility and reliability of the measure rather than the level of adherence of the treating teams.

A 25 audio-recordings across five OD trial sites were collected for this study. Based on a literature review, this number was deemed to be acceptable and appropriate for this research (Williams et al., 2011; Pantalon et al., 2012; Gillespie, 2014; Roth, 2016). This total represented 3 audio-recordings from NELFT, 12 from KMPT, 2 from BEH, and 8 from DPT. Session length ranged from 33.02 to 115.5 min.

As this research took place in the initial pilot study stage of the RCT, no additional information was collected about service-users or practitioners other than what was on the tapes. In some sessions, introductions were made at the beginning of the recording which assisted raters in distinguishing between network member and practitioner voices. However, this was not done as standard to preserve anonymity. Therefore, it is unclear how many tapes may have been recorded by the same treating pairs or with the same network. Due to the small size of treating teams it is likely that practitioners appeared more than once on the recordings, however, there appeared to be considerable variation in service-users and networks. As tests in this study were conducted on raters rather than therapists/families this was deemed acceptable.

Initially a random number generator was used to organize the five raters into pairs and randomly allocate the tapes for independent rating. However, as the audio-recordings were collected at different time periods from December 2018 to May 2019, audio-recordings that were collected at later dates were rated purposively by available raters.

All raters except for the primary researcher were blind to their rater pairings. Raters were not given any information about scoring until after their sessions had been submitted. The primary researcher scanned score sheets for large discrepancies (for example if one rater passed a session while another failed it) and contacted raters about these sessions. This occurred on four occasions. For training purposes, raters were requested to revisit these scores, however, at no time did they see the scoresheet of the other rater. The initial scores submitted were used in the analyses.

3.7. Analyses

3.7.1. Face/content validity

A modified Delphi technique (a method of consensus building using questionnaires) was used to gather data from respondents within their domain of expertise (Hsu and Sandford, 2007). This was done using the Qualtrics Survey Software, a free online platform for the development and data management of research surveys. Individuals with expertise in OD were contacted *via* email and sent a link to the online survey. The initial questions related to whether or not the 12 key fidelity items reflected key elements of OD practice as seen in a network meeting. Survey participants were asked to respond to this on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Respondents were then asked three further open response questions about whether they viewed these items as necessary and relevant, and whether they would make any further changes or amendments to these items. The final survey consisted of 12 Likert-response items, three qualitative feedback questions, and three respondent demographic questions.

3.7.2. Inter-rater reliability

Statistical analyses were conducted using SPSS 25. Intraclass correlation coefficients (ICCs) were calculated for all pairs of coders to estimate reliability. The convention developed by Cicchetti (1994)'s for evaluating the usefulness of ICCs was adopted for the current study and is as follows: below 0.40 = poor, 0.40 to 0.59 = fair, 0.60 to 0.74 = good, and 0.75 to 1.00 = excellent. ICC was calculated using a two-way random model with absolute agreement as per recommendations by Shrout and Fleiss (1979) for each adherence item independently as well as scale total.

3.7.3. Internal consistency

Cronbach's alpha coefficients were computed as a measure of internal consistency. A threshold of >0.70 (good) was used as a standard threshold of internal reliability (Bernstein and Nunnally, 1994). Cronbach's alpha was selected due to the use of Likert rated items in the measure. Likert items were considered on an ordinal scale in these analyses. Reliability coefficients were inspected at the item level to determine whether or not any single items significantly impacted the overall reliability of the scale.

4. Results

4.1. Measure development

The final manual was 18 pages covering the rating process and defining the key elements of OD. The retained information and descriptions enhance understanding of meaning underlying the different elements and anchor the coding framework. The anchor points describe why a rater may give a key element a certain rating. They help to distinguish a 1 (not at acceptable level), 2 (acceptable), 3 (good), and 4 (excellent). They also clearly outline when certain decisions should be made as well as the pass/fail criteria (Forsberg et al., 2015). The four-point scale was used as it had been developed in the original manual and initial comparisons showed reliability between raters with this format. Additional anchor points on the scale would have made the rating process more complex as a greater number is likely to increase the systematic variance and redundancy in a scale (Jaju and Crask, 1999).

As part of the rating process and, in line with the definition of adherence described above, it was important to get a measure of "dose" – in this case a count of specific OD-related therapeutic techniques used within the session. In order to do this, collaborators agreed it was important to rate every "utterance" made by a practitioner. This also helped to establish the proportion or monologic versus dialogic utterances and a cut-off was established regarding the necessary proportion for a session to be true to the OD model. Collaborators created a structured table with definitions of the key elements as well as monologic items. This allowed users to tally the practitioners' "utterances" to inform the subsequent ratings.

The 12 Likert-rated items on the scale reflect the 12 fidelity criteria (Olson et al., 2014; see Table 1), with each principle represented by one item. The first two items are structural and relate to the individuals in the room, i.e., number of practitioners and involvement of the network. The subsequent 10 items reflect the key therapeutic elements of the OD model. Final scores on the measure can range from 12 to 48. A score below 22 is considered to not be adherent (as this would represent more than two items rated as not at an acceptable level).

In order to rate these 12 items, the manual advises raters to refer to the tallies made within the utterance table and use these to inform their decision making. Simple presence or absence measures were not appropriate for use in this model because OD network meetings are led by the service-user and network and, therefore, clinicians cannot be expected to engage in all OD skills at similar levels in every meeting.

At the end of the coding sheet an overall adherence rating is taken on the basis of three general questions. In order for a session to be considered adherent a score of "Yes" has to be answered on all three yes/no questions stated below.

1. Was the proportion of dialogic statements at least two-thirds (0.67)?
2. Were at least 8 of the 10 fidelity items in Section B at the level of "Acceptable" or higher?
3. Were there fewer than two instances of patronizing or disrespectful statements?

4.2. Validity

4.2.1. Face validity

A large extent of face validity of the measure was established through the parallel development process in both the United States and United Kingdom. The measure was also based on the theoretical concepts outlined by Olson et al. (2014) which provides a strong theoretical grounding based on international expert opinion.

4.2.2. Content validity

Twenty-nine individual responses were received *via* the Qualtrics Survey Software. Survey participants varied in levels of training/experience from expert >5-years ($N = 12$), advanced 2-5-years ($N = 11$) and beginner <2-years ($N = 6$). All individuals were actively researching or practicing OD and therefore all had large amounts of knowledge in the area. Nine participants were primarily involved in OD research, 9 in OD practice and 11 involved in both research and practice. Participants represented an international sample (Australia = 4; Belgium = 1; Finland = 5; France = 1; Germany = 2; Italy = 1; Japan = 1; Lithuania = 2; Norway = 1; Netherlands = 2; United Kingdom = 7; United States = 1; Unknown = 1).

Results from question one of the survey are presented below in Table 1. Participants were asked "To what extent do the following items represent key elements of OD Practice as would be seen in a network meeting?" and respondent on a Likert scale as described in the methods. Mean ratings for each element was above 4.0 representing agreement for all 12 items.

Participants were also asked the following open response questions: (1) What you would add to the scale? (2) What would you remove from the scale? and (3) Is there anything you would change? These questions received variable responses and are presented below (see Figures 2–4).

Overall 6 of 29 survey respondents suggested items that they would add to the scale (see Figure 2). Many of these responses

TABLE 1 Key elements survey results.

#	Key element	Mean	Min.	Max.	SD	Variance	Count
1	Two (or More) therapists in the team meeting	4.66	1.00	5.00	0.84	0.71	29
2	Participation of family and network	4.66	2.00	5.00	0.71	0.50	29
3	Ongoing use of open-ended questions throughout the treatment meeting as a way of linking client utterances and building dialog	4.38	3.00	5.00	0.67	0.44	29
4	Responding to clients' utterances: This includes responsive listening, using the clients' own words and tolerating silences in conversation	4.79	3.00	5.00	0.48	0.23	29
5	Emphasizing the present moment: Responding to immediate reactions and emotions but not interpreting or agenda setting	4.52	3.00	5.00	0.56	0.32	29
6	Eliciting multiple viewpoints: Outer and inner polyphony engaging everyone in the meeting and multiple viewpoints in an individual	4.83	4.00	5.00	0.38	0.14	29
7	Use of a relational focus in the dialog: Focus on the relational aspects of spoken stories to define relationships and elicit contextual and social information	4.24	3.00	5.00	0.68	0.46	29
8	Responding to problem discourse or behavior in a matter-of-fact style and with meaningful dialog: Seeing symptoms as "natural" responses to stressful life situations	4.41	2.00	5.00	0.77	0.59	29

(Continued)

TABLE 1 (Continued)

#	Key element	Mean	Min.	Max.	SD	Variance	Count
9	Emphasizing the clients' own words and stories, not symptoms: Help client find words to communicate more clearly, pay attention to one word or sub-sentences	4.69	3.00	5.00	0.53	0.28	29
10	Conversation amongst professionals (reflections) in the treatment meetings	4.48	3.00	5.00	0.72	0.53	29
11	Being transparent: Shared decision making. Disclosing Information on all discussions at the treatment meeting to all members present, sharing what clinicians do know and do not know	4.76	3.00	5.00	0.50	0.25	29
12	Tolerating uncertainty: No hasty judgments about symptoms, diagnosis or treatment, understanding and responding to the whole person in context rather than reacting to isolated behaviors	4.83	4.00	5.00	0.38	0.14	29

Are there any items that you would add to the scale? If so, what and why?

1. No, I think the essential moments already are in the scale.
2. Emphasizing personal ways of responding instead of "pure" professionalism.
3. Continuity, immediate response
4. Bringing yourself to the sessions, your genuine responses and owning these
5. To be open and honest about boundaries that you have or don't have in contact with somebody, so that you can be fully open to the persons and that moment, not that there is transparency about expectations of care.
6. I would add some items to assess different level of adherence between team members
7. No
8. Measures of communicative success - what is the point of being dialogical if there is no evidence that you understood them?
9. No

FIGURE 2
Items to add to the scale.

Are there any items that you would remove from the scale? If so what and why?

1. No
2. No
3. No, these are the essential moments, or let's call them "key elements" of the Open dialogue practice in the meeting.
4. No
5. No
6. N/A
7. Participation of family/social network is desirable but not necessary - many people are in crisis because of a lack of social support
8. There are too many items and many are overlapping
9. To me items 4 and 9 seem to be covering nearly the same issue - could these be combined?
10. I don't think so.

FIGURE 3
Items to remove from the scale.

Is there anything else you would change about the items on the scale?

1. No
2. No
3. No
4. I would amend the wording of item 2 as sometimes individuals do not want the network involved
5. The above fits with transparency but is more than
6. 4th and 9th items seem to express the same thing. They might be merged.
7. I would use the same Likert scale to evaluate ability and adherence. For example: the assignment of "2" in the codification of ability means "somewhat" while in the case of adherence means "fair". In our experience, this discrepancy was even more evident after data analysis. Another change I would like to propose is to use a 5 or 7 points Likert scale to make more space for critical evaluation. In fact, our impression is that the scale framed the sessions more positively that actually perceived by the raters.
8. Slightly less wordy and more helpful to define the key element
9. No
10. N/A
11. Well, the thing for me (mainly as a trainer also) is, that in different contexts it might be useful to adapt to the people in the room, or to join them from where they come. Open Dialogue rules should not be followed in a rigid way, but also flexible, dependent on the context. Whether you practice in an Institution or do home treatment, you have to be flexible. And from my Point of View there is no "One" right way to do it. Is many times a process towards. If this could be expressed also within the questions I would appreciate it. Open Dialogue is a way to more connection is not a set of rules.
12. Include importance of 1:1 sessions whether that's with a Peer, OT, nurse etc spaces are created where client can confide abuse or concerns away from the network environment where their voice maybe silenced.
13. Points 7 and 8. I think we need to be vary that the focus on "relational focus" or "problem discourse" doesn`t become a "thing" or agenda...how to maintain the dialogicity and dialogical aspect throughout the whole process. For example how to honour and respect people`s "problem discourse" if they find it helpful?
14. Emphasis on the conversation, and not that much on the solutions.
15. Not in this moment

FIGURE 4
Changes to the scale.

(i.e., numbers 1, 4, and 5) related to openness of response and genuineness of clinicians. Response 3 refers to an aspect of OD team structure better captured in a fidelity measure. And, response 6 advises different measures of adherence for each clinician to capture cases when one clinician may be more or less adherent than the other.

Only three of 29 respondents suggested removing any items from the scale (see Figure 3). Two of these suggested potential overlaps between items, e.g., items 4 and 9. The other response suggested decreasing the relevance of social network participation within the measure.

The final question about changes to the scale received the most responses, however, many of these responses advocated keeping the present measure (see Figure 4). One response (number 7) recommended changes in scaling used. Two (4 and 6) echoed changes advised in Figure 3 to item 2 and combining items 4 and 9. Response 12 refers to additional interventions outside of network meetings which is outside the remit of this measure. Many responses reflect the importance of clinicians being flexible and not applying specific techniques unless it fits with the nature of the current network meeting.

4.3. Scale output

Means and standard deviations for each item were computed (see Table 2). Average over all score was 33.16 out of 44 ($N = 50$) showing that, overall, sites were adherent as rated on the measure. Average scores on each item ranged from adherent to good with the lowest average score on item 7 (relational focus) and the highest average score on item 4 (responsive listening).

4.4. Reliability

4.4.1. Inter-rater reliability

Inter-rater reliability for the total score was excellent. The average measure ICC was 0.906 with a 95% confidence interval from 0.785 to 0.958 [$F(24,24) = 10.254$, $p < 0.001$]. ICCs for each discrete item ranged from fair to excellent with most items in the good ($N = 6$) and excellent ($N = 5$) range. The one item which fell below this was item 4 (responsive listening; ICC = 0.573).

4.4.2. Internal consistency

Calculation of Cronbach's alpha for the 12 items was highly reliable ($\alpha = 0.848$). There was no item that could be removed from the scale to substantially increase internal consistency and all items had high item total correlations.

5. Discussion

The aim of this study was to develop and psychometrically formalize a measure of OD practitioner adherence for use in the United Kingdom-based ODDESSI RCT. The initial goal of this study was to develop and refine the DPAS (in development) which had previously been developed to rate dialogic practices within network meetings. However, as the study progressed a new measure was developed, and this is presented here. Validity of the new OD Adherence Scale has been established and internal consistency statistics report that the scale is reliable meeting the initial aims of this research project.

This is the first study to analyze the psychometric properties of the OD Adherence Scale and the results from the application of the measure provided initial adherence data which was required by NIHR in the feasibility stage of this trial. Using the scale, it was found that therapists practicing OD in the participating NHS trusts were adherent in delivery of core OD interventions. Average scores were in the adherent to good range overall and for individual items. This was true across trusts who served different populations and therefore had variability in the presentations seen within their services. It also held true with different network types and compositions.

Psychometric properties of the scale suggest that this tool may be useful in assessing adherence in OD. Modified Delphi results show that OD experts and new practitioners agree that the scale represents the key elements of the OD theoretical model. There were minimal changes suggested for the scale and many of these related to elements that would be better covered in a fidelity scale or items that are not easily operationalized for an observer rated tool. For example, individual support offered to the service user outside of network meetings would not be something observable in network meetings and would require additional interviews with service users and staff which is outside of the remit of this measure.

The use of different levels of adherence rating (adherent, good and excellent) allows the rater to make judgments about how the intervention was received by the network, whether it was appropriate, and whether or not it worked well in the context. The use of these additional rating points allows for flexibility in the sessions and addresses concerns about the rigidity of the scale described in the results. For example, neither the manual nor the measure specifies the number of occurrences of a technique for reliability. Therefore, a technique can still be rated as excellent despite occurring infrequently while another may be rated as poor in spite of occurring many times during a session. This is important for a therapeutic model such as OD with a focus on unique and flexible responses to each network in each session.

Inter-rater reliability for the overall adherence score was excellent (Shrout and Fleiss, 1979). High inter-rater reliability indicates that two randomly selected raters reliably discriminated clinician's use of and competence in different therapeutic techniques (Haddock et al., 2001) and the excellent overall score suggests that the OD Adherence Scale is a highly reliable measure. ICC ranged from fair to excellent across the items with the lowest score for item 4 responsive listening. Systematic differences between raters would likely be due to differing levels of experience both in clinical work and in OD practice. However, agreement was high for the overall score and 11 of the 12 items suggesting that training completed as part of the measure development process was sufficient, even for those with less experience with the OD model. It also shows that the measure is accessible to those with

TABLE 2 Inter-rater reliability and adherence descriptors.

Item	Description (*N*=25)	Mean Score	SD.	ICC
Total		*33.16*	*6.011*	*0.906*
Avg.				
1	Two (or More) therapists in the team meeting	3.06	0.682	0.612
2	Participation of family and network	2.64	0.898	0.792
3	Ongoing use of open-ended questions throughout the treatment meeting as a way of linking client utterances and building dialog	2.62	0.878	0.675
4	Responding to clients' utterances: This includes responsive listening, using the clients' own words and tolerating silences in conversation	3.16	0.889	0.573
5	Emphasizing the present moment: Responding to immediate reactions and emotions but not interpreting or agenda setting	2.68	0.891	0.824
6	Eliciting multiple viewpoints: Outer and inner polyphony engaging everyone in the meeting and multiple viewpoints in an individual	2.52	0.839	0.707
7	Use of a relational focus in the dialog: Focus on the relational aspects of spoken stories to define relationships and elicit contextual and social information	2.24	0.847	0.669
8	Responding to problem discourse or behavior in a matter-of-fact style and with meaningful dialog: Seeing symptoms as "natural" responses to stressful life situations	2.84	0.766	0.734
9	Emphasizing the clients' own words and stories, not symptoms: Help client find words to communicate more clearly, pay attention to one word or sub-sentences	3.04	0.781	0.704
10	Conversation amongst professionals (reflections) in the treatment meetings	2.58	0.835	0.727
11	Being transparent: Shared decision making. disclosing information on all discussions at the treatment meeting to all members present, sharing what clinicians do know and do not know	2.72	0.757	0.678
12	Tolerating uncertainty: No hasty judgments about symptoms, diagnosis or treatment, understanding and responding to the whole person in context rather than reacting to isolated behaviors	2.90	0.735	0.625

Italicized values are the total adherence scores.

less exposure to OD and general clinical work increasing its utility in different contexts.

The measure also demonstrated a high level of internal consistency (as reported by Cronbach's alpha) suggesting that it is a reliable measure of the intervention and that competent delivery of one individual therapeutic technique is related to competent delivery of the others (Forsberg et al., 2015). However, Cronbach's alpha is not a measure of how many constructs were measured by the scale. Additional data along with further investigation is needed to explore whether OD adherence can be efficiently rated as one global dimension.

5.1. Limitations

An important limitation of this study is the limited sample size. Significant resource is required to rate full length therapy sessions (Perepletchikova et al., 2009) and this is particularly true of OD sessions which can range from 40-min to two-hours in length. Ideally, each of the five individual raters would have independently rated each OD tape but such resource was not available for this study. Low sample size may have contributed to variability in inter-rater reliability and internal consistency, which may have been improved with a larger sample (Shrout and Fleiss, 1979; Forsberg et al., 2015).

Additionally, there was a large time delay in receiving audio-recordings from sites which impacted the randomization process. Raters were initially randomized into pairs and to tapes but this process became purposive nearing the end of the study due to time constraints. Randomization of recordings was conducted by session, not by participant or site, therefore we had different numbers of sessions per site and there may have been some sampling bias by clinicians. As this research took place in the pilot stage of the trial, we did not collect identifying information about service users or practitioners which did not allow us to determine the impact of who was recorded on reliability outcomes. This information will be collected at later stages in the trial.

5.2. Strengths and future directions

The OD Adherence Scale is the first attempt to identify and operationalize the key elements of an OD network meeting. This study provides evidence of a consensus on the key elements of OD network meetings and dialogic practice. A strength of this research is having a varied and international team of researchers involved in the development of the measure. The parallel development processes in the United Kingdom and United States provides additional evidence of the validity of the measure. The scale presented here is an initial attempt at rating practitioner adherence in these meetings. It provides encouraging evidence that this can be done with good validity and reliability and can be completed by a range of raters with different levels of clinical experience. The scale is easy to use and does not take much longer than a network meeting to complete. It will be an important addition to OD implementation research which must report on whether OD theoretical techniques are being used adequately in practice.

This study also provides initial psychometric information as the foundation for future research and additional validation of the OD Adherence Scale. It is recommended that, as more data is collected using the measure, further analyses be performed such as those listed in the above limitations. This will improve our understanding of the measures psychometric properties providing additional evidence for or against its utility moving forward.

The manual produced as part of this research has now replaced those in development. It is being used to train raters in the United Kingdom and internationally as countries implement OD into their mental health care systems.

6. Conclusion

Perepletchikova and Kazdin (2005) propose that, in order to achieve greater scientific validity, studies looking at the relationship between fidelity and outcome should investigate empirically supported treatments, use validated fidelity measures rated by non-participant judges, and control for third variable influences. This study provides the initial element of this process for the ODDESSI program by providing psychometric information on the OD Adherence Scale.

Monitoring adherence is necessary for assessing whether participants or service users are receiving the appropriate evidence-based treatment and to identify when and how this goes wrong (Walton, 2018). It has implications for providers and wider systems and leaves us with ethical questions about how we should deliver treatment. While "perfect or near-perfect" implementation is unrealistic (Dulak and DuPree, 2008) it remains important to measure fidelity of delivery and to report on it transparently and clearly in order to translate interventions into real world settings (Walton, 2018).

Knowledge of fidelity and adherence in OD needs further development. This study is an important first step in the OD Adherence Scale's evaluation and validation. However, the initial results presented here provide a promising foundation for the OD Adherence Scale's utility within OD research projects.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Author contributions

ML wrote the text of this article and completed all surveys and statistical analyses. DZ provided a measure that he had begun development on (as described in the text). ML, RR, MA, and MH met to determine key features of OD and developed iterations of the original measure. ML, RR, MA, MH, and EW trained together to rate tapes and acted as raters and were involved in meetings to discuss and determine reliability. SP provided the idea for this research project as well as mentorship throughout and acted as an editor of this text and provided ideas for analyses. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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The community mental health team fidelity scale: A measure of program fidelity of social networks interventions for severe mental illness

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Open dialogue (OD) is a multi-component therapeutic and organizational intervention for crisis and continuing community mental health care with a therapeutic focus on clients' social networks. The development and implementation of this model of care in the United Kingdom requires considerable contextual adaptations which need to be assessed to support effective implementation. Program fidelity–the extent to which core components of an intervention are delivered as intended by an intervention protocol at all levels–is crucial for these adaptations.

Aims: To develop, pilot, and implement a program fidelity measure for community mental health services providing OD and 'treatment as usual' (TAU) or standard NHS crisis and community care.

Methods: Measure structure, content, and scoring were developed and refined through an iterative process of discussion between the research team and OD experts. Measure was piloted in the 6 OD and 6 TAU services participating in a large-scale research program.

Results: Initial data suggests that the Community Mental Health Team Fidelity Scale (COM-FIDE) is a potentially reliable and feasible measure of the fidelity of community mental health services and specific OD components of such services.

KEYWORDS

open dialogue, fidelity, implementation science, community mental health, measure development, severe mental illness, complex interventions

Introduction

Poor social networks have been associated with both the development and maintenance of mental illness (Giacco et al., 2012). Interventions targeting social networks–such as the Open Dialogue (OD) approach (Seikkula et al., 1995) might therefore help ameliorate mental health crises and reduce the likelihood of relapse. However, due to limited staff training and skills, and a lack of continuity associated with the current model of crisis and continued community care of the British National Health Service (NHS), such interventions are not currently provided (Razzaque and Wood, 2015; The Commission on Acute Adult Psychiatric Care, 2015). Further, the professional and contextual adaptations required to integrate OD successfully and sustainably

into NHS models of care require a consideration of the model's core components.

Program fidelity or the extent to which core components of an intervention are delivered as intended by a treatment protocol is a useful approach to supporting effective implementation (Santacroce et al., 2004; Borelli, 2011; Gearing et al., 2011). This paper outlines the development, piloting, and implementation of a program fidelity measure for the OD approach: The Community Mental Health Team Fidelity Scale (COM-FIDE). The paper begins with a brief description of Open Dialogue and the current NHS model of crisis and continuing community care in mental health. This is followed by an exploration of some of the challenges involved in integrating OD into the provision of mental health services in the United Kingdom, including the challenges in developing a fidelity measure. The COM-FIDE development and piloting method are then outlined, alongside some preliminary psychometric data. Finally, results are considered alongside the utility of COM-FIDE.

Crisis and continuing community mental health care in the United Kingdom

The NHS is facing significant problems in providing care and support for people with severe mental illness, potentially due to poorly developed and increasingly fragmented pathways of care (NHS Confederation, 2016; The Kings Fund, 2016). This is in part a consequence of the functional model of mental health care, where care is often provided by several different teams, each with its own criteria for acceptance (Morton and Norman-Nott, 2019). Standard NHS crisis and continuing community care services for people experiencing severe mental illness consist primarily of crisis resolution and home treatment teams (CRTs) and community mental health teams (CMHTs). As an alternative to hospitalization, these multidisciplinary teams–typically conformed by psychiatrists, mental health nurses, social workers, and support workers–provide intensive assessment, care, and support in patients' homes (Weisman, 1989; Jethwa et al., 2007; Johnson, 2013). Standard care often acknowledges and may attempt to work with the social network of a person in crisis; however, their brief and functional nature and the pressures on service resources make this form of ongoing network-oriented care a challenging endeavor (Razzaque and Wood, 2015).

Despite the promise shown in randomized controlled trials (Johnson et al., 2005a,b; Lloyd-Evans et al., 2014, 2019), questions have been raised on whether standard care might be decreasing in effectiveness (Johnson et al., 2005a,b; Jacobs and Barrenho, 2011). Wheeler et al. (2015) suggested this might be due to a considerable atrophy of its key functions, with many services offering limited home visits outside of office hours and only 50% of services providing post-hospital discharge care. It is important to ask whether this possible decrease in the quality of community-based services can be explained by a lack of resources or if organizational problems, such as staff competencies, roles, care pathways, or fidelity to a model, may also be contributory factors.

Open Dialogue

Open Dialogue (Seikkula et al., 1995) is both a therapeutic approach and a way of organizing mental health services developed in Finland, which explicitly targets social networks. The aim of Open Dialogue is to promote a greater shared understanding of service users' problems, a greater sense of agency, collaborative decision-making, and the network's mutual support in the long term (Seikkula et al., 1995, 2006; Seikkula et al., 2001a, 2011). This is done through the enactment of the principles of (1) immediate help, (2) social networks perspective, (3) flexibility and mobility, (4) responsibility, (5) psychological continuity, (6) tolerance of uncertainty, and (7) dialogue and polyphony (Seikkula et al., 1995). In contrast to current models of care–in which families may not be directly involved–Open Dialogue uses network meetings attended by family members, friends, and other professionals involved with the service user as the central means of intervention delivery (Seikkula et al., 1995; Seikkula and Olson, 2003; Lakeman, 2014; Razzaque and Wood, 2015). Service users and their social networks engage in shared decision-making with healthcare professionals to agree on appropriate pharmaceutical, psychological, or social interventions (Seikkula et al., 2006; Olson et al., 2014).

The development of an integrated OD approach to the provision of mental health services offers the possibility of an alternative to the current 'functional team' model of care in the United Kingdom (Hopfenbeck, 2015; Razzaque and Stockmann, 2016). Preliminary evidence suggests that OD may be more effective than standard care in reducing relapse and the use of antipsychotic medication (Seikkula et al., 2001b, 2003; Hartman and De Courcey, 2015; Bergström et al., 2018). Additionally, OD might help equip mental health staff with additional skills necessary to engage service users and their families across the broad spectrum of care needs (Holmesland et al., 2014). However, although promising, there is no high-quality evidence to date to support an NHS-wide adoption of this model of care.

Program fidelity measurement

Transferring Open Dialogue from one health care setting to another requires considerable contextual adaptations that could undermine structural (i.e., organizational) and process (i.e., therapeutic) components of the original model (Gonzalez Castro et al., 2004). In fact, international OD implementation programs (e.g., Pocobello and Salamina, 2015) have noted that the organizational change is such, that staying faithful to the OD principles (e.g., Seikkula et al., 2006; Olson et al., 2014) has encountered significant obstacles. Program fidelity or the extent to which an intervention is delivered as intended in a treatment protocol at all levels can be a useful tool for understanding an intervention's critical components on a structural, organizational, and functional level (Carroll et al., 2007; Proctor et al., 2011; Teague et al., 2012).

Literature suggests that program fidelity measures should involve (1) an evidence-based, comprehensive, and multimodal approach to assessment, (2) clearly and objectively operationalized components stemming from a coherent and comprehensive theory of change, and (3) easily-available data from the relevant stakeholders (Schoenwald et al., 2011; Essock et al., 2015). Although uncommon, existing measures for multi-component interventions such as OD are somewhat consistent in terms of measure design, assessment procedures, and scoring. Donabedian (1988) suggested a structure-process-outcome framework for fidelity evaluation; however, most measures emphasize structural features of service provision (e.g., operations, staffing, or services provided) but tend to neglect

important process and outcome features relevant to the therapeutic model (Alvarez-Monjaras, 2019).

A few efforts have been made to establish appropriate fidelity measures for standard crisis and continuing community care. The CORE CRT (Lloyd-Evans et al., 2016) is the most robust and validated measure to date for crisis services. However, OD implementation studies so far have focused on practitioner adherence or the quality of delivery of network meetings according to the key OD principles (Eiterå et al., 2014; Olson et al., 2014; Rambøll, 2014; Ziedonis et al., 2018; Lotmore et al., 2022). Since OD is not only a therapeutic model but also a way of organizing care, it is important to identify not only the clinically relevant (i.e., process) features but also the structural and organizational features that characterize the approach and distinguish it from standard care. In other words, if OD is to be successfully implemented and integrated into the traditional NHS model of crisis and continued community care, it is essential to develop a program fidelity measure to support the implementation of OD that is faithful not only to the original Finnish model, but also fit for its incorporation into the NHS.

Study aims

This study was part of the NIHR ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) program grant (RP-PG-0615-20,021). ODDESSI aims to evaluate whether OD –when integrated within standard NHS mental health services for adults in crisis–improves the clinical and cost-effectiveness of standard crisis and continuing community mental health care (i.e., CRTs and CMHTs). The ODDESSI is a cluster-randomized controlled trial (RCT) consisting of five work packages oriented toward defining, implementing, and evaluating OD services across 28 trial clusters from five NHS trusts (for full protocol see Pilling et al., 2022).

The key goal of the present study was to develop, pilot, and implement a program fidelity measure that could accurately characterize the quality of both standard NHS crisis and continuing community care (hereafter referred to as 'treatment as usual' or TAU) and high-quality OD practice. If successful, this measure would provide information on whether: (1) NHS services, once reorganized on an OD model of care, can deliver OD with sufficient fidelity to its core principles and ensure they are both provided effectively; (2) it is possible to distinguish OD services from standard care based on their model of work; and (3) there are any differences in implementation between each model's teams.

Methods

Study design

Although this specific study was relevant to all work packages of the ODDESSI trial, it was embedded in the second work package as part of the feasibility stage (WP2). WP2 addressed the feasibility of a cluster RCT, including the question of whether adherence and fidelity measures could provide a reliable measure of OD practice. Additionally, the NIHR shared their concern that–in order to draw meaningful conclusions from the outcomes–the trial needed to be able to compare OD teams against high-quality TAU. Developing a program fidelity measure is one way of ensuring high quality of care in both OD and TAU.

Participants

Participants for this study were staff members from six OD services and their six TAU counterparts. For each service, one pair of managers and one pair of practitioners (i.e., psychiatrists, psychologists, psychotherapists, nurses, social workers, and support workers) were interviewed by two joint independent raters. A total of 48 staff members were interviewed.

Ethical approval

This study received ethics approval from the Health Research Authority under reference number 18/LO/0026. No personal or confidential information was solicited. Participants gave consent for being recorded using an encrypted and password-protected recorder.

Measure development

The Community Mental Health Team Fidelity Scale (COM-FIDE) was developed following a stepwise approach (Bond et al., 2000; Holmbeck and Devine, 2009), based on our systematic review of existing measures (Alvarez-Monjaras, 2019), and a series of discussions with experts (Figure 1).

Defining the content and scope of the measure

The initial content, method of delivery, and scoring process of the COM-FIDE builds on work done at University College London on the 'Children and Young People – Resource, Evaluation and Systems Schedule' (CYPRESS) (Gaffney, 2012) and findings from our systematic review. CYPRESS was developed for the Systemic Therapy for At-Risk Teens (START) RCT (Fonagy et al., 2013) to characterize services delivering multisystemic therapy and management as usual for young people with complex presentations. CYPRESS captures key elements of effective implementation efforts (e.g., coherent theoretical basis, high program fidelity, qualified staff, sustained approach, etc.) across three levels of service delivery: service characteristics, team operations, and delivery of interventions. The promising results from the START trial suggested that CYPRESS could be a robust measure for service characterization.

Drawing on the CYPRESS (Gaffney, 2012), our systematic review, and Donabedian's (1988) structure-process-outcome framework, the research team agreed to four broad key domains to assess: (1) team structure and culture, (2) access to and engagement with services, (3) delivery of care, and (4) external support. An initial list of items was drafted and then refined based on three factors: (1) a focus on adult mental health, (2) the ability to encompass both OD and TAU, and (3) the ability to identify high-quality TAU.

Designing the measure

The refinement and detail of the measure outline was established through a series of meetings and discussions between the main author

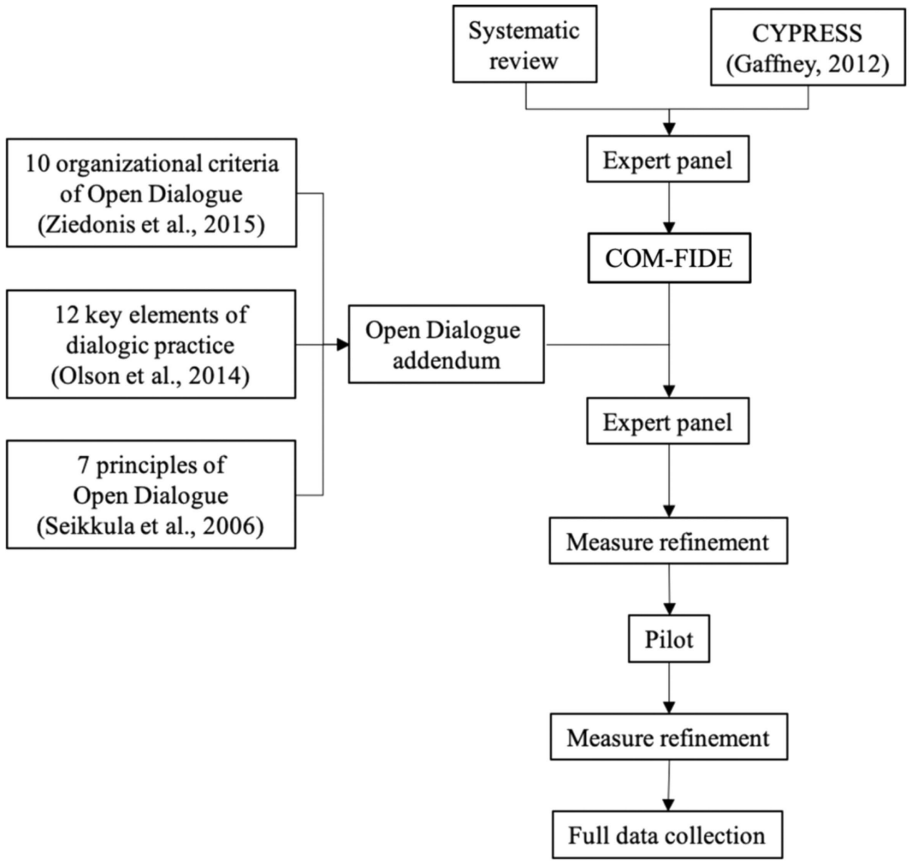

FIGURE 1
Community Mental Health Team Fidelity Scale (COM-FIDE) development process.

(MA, Clinical Psychologist), SP (Clinical Psychologist with expertise in evidence-based practice and experience in measure development), RR (Consultant Psychiatrist, ODDESSI co-applicant, and international expert in OD), MH (Lead OD trainer), and ML (Clinical Psychologist involved in the development of the adherence measure). An iterative process, aimed at achieving an acceptable level of utility of the measure, took place between October 2017 and January 2018.

Open Dialogue fidelity

Another important goal of WP2 was to refine the OD protocol for its implementation across NHS sites. Consequently, the resulting measure needed to be able to recognize features specific to open dialogue in OD teams. A similar item development process for an OD addendum took place based on existing OD literature (e.g., Seikkula et al., 2006; Olson et al., 2014; Ziedonis et al., 2015), and the ODDESSI treatment protocol. The ODDESSI protocol set out key functions, referral pathways, and governance arrangements of each site, and was developed by the research team in collaboration with experts in OD and TAU, alongside senior NHS staff and clinicians.

Given the complexity of OD terminology, a series of discussions around the main theoretical principles (e.g., dialogism, transparency, openness) were arranged with OD experts. The aim was to determine the best possible way to translate these key principles into objective and reliable service-level items that could be ascertained by raters not trained in OD.

The community mental health team fidelity scale

The above led to the development of a 25-item Community Mental Health Team Fidelity Scale (COM-FIDE, formerly CoMFideS). COM-FIDE is a measure designed to describe the structure, functioning, pathways, community links, and delivery of care provided by good quality community MH services, including OD. COM-FIDE is hence a measure of program fidelity of both (a) standard NHS crisis and continued community care and (b) best practice in OD delivery. The COM-FIDE also includes a 7-item Open Dialogue Addendum focused on measuring the level of fidelity to open dialogue principles of care.

The first section of the COM-FIDE concerns structural aspects of the services under assessment. The COM-FIDE comprises four sections that assess the level of fidelity of mental health teams–regardless of their model of care–to high-quality crisis and continued community care: (1) Team structure and culture (8 items); (2) Access and engagement (6 items); (3) Delivery of care (6 items); and (4) External and support (5 items).

Measure refinement

The COM-FIDE was piloted in one OD and one TAU service to identify areas of improvement in the COM-FIDE and assess the

measure's acceptability. For each team, two managers and two practitioners were interviewed using the draft measure, followed by a brief discussion on its structure, content, and acceptability. Using the outcome from the pilot, the measure was once again refined and discussed with the expert panel (See Figure 1).

The COM-FIDE manual

Based on initial work gathered throughout the measure development process and drawing from CYPRESS (Gaffney, 2012), a manual was developed (Available on the UCL ODDESSI website). The manual includes a description and rationale for each item alongside their respective behavioral anchors for scoring (Alvarez-Monjaras and Pilling, 2019).

Measure pilot

Recruitment and setting up the interviews

As per the manual, initial contact with services was done *via* email correspondence, describing the study, its purpose, and a brief description of the measure and interview process. Service documentation (e.g., staffing, supervision, safeguarding, and operational policies) was also requested from each Trust to gather service-level data. Interviews typically lasted no more than 60 min. The average time spent per interview was 46 min (range = 35–57). None of the raters were OD-trained but were all clinicians trained on the use of COM-FIDE, which included discussions of each item and rating examples.

Agreeing on final ratings

Once each interview session was completed, both raters reviewed their individual score sheets separately. Each item was then jointly reviewed to identify and record disagreements and a consensus reached on the final score.

Scoring and cut-off scores

During each interview, both raters simultaneously and independently rate a copy of the COM-FIDE. Once finished, they review and reach a consensus in the ratings. All items of the COM-FIDE are rated on a 4-point behaviorally anchored Likert scale. Advised that a 4-tier structure might offer the highest level of precision possible for rating program fidelity, rather than the traditional 5-point Likert approach. On all items, a score of one indicates that the principle at hand is not present or there is insufficient evidence of its enactment in the team's way of functioning, whereas a score of 4 indicates that the principle is enacted or carried out in an excellent manner and with no visible shortcomings or inconsistencies across the team. The overall COM-FIDE score yields to a final score of 100 and the OD-addendum to a score of 28. Each section then obtains an average score of its composite items (for more information on scoring and all behavioral anchors, please refer to the manual on the UCL ODDESSI website).

Providing (1) this is the first fidelity measure developed for open dialogue in the NHS, and (2) that there are no pre-existing criteria for what constitutes a 'good' standard of TAU care, nor of open dialogue fidelity, we considered 4 fidelity gradations: an average score on each section equal or above 3.40 (85th percentile) was considered 'very good'; scores between 2.80 and 3.39 (70-85th percentiles) as 'good'; scores between 2.40 and 2.79 (60-69th percentiles) as 'acceptable'; and scores equal or below 2.39 (below 60th percentile) as 'poor' or lacking fidelity.

Data analysis

Data from each site consisted of: (1) three rating sheets (i.e., two independent rating sheets and a final rating sheet) for manager interviews, and (2) three rating sheets for practitioner interviews. Data from all rating sheets were entered into an Excel spreadsheet and later exported onto an SPSS database. All analyzes were conducted using IBM SPSS Statistics version 25 for Mac (IBM Corporation, 2017). Descriptive statistics and radar plots were used at service level to characterize site fidelity scores. Statistical tests comparing scores were not conducted given the small sample size.

Psychometric properties

The present study explored–albeit tentatively–the following psychometric properties of the COM-FIDE: (1) inter-rater reliability, (2) internal consistency, and (3) face and content validity.

Reliability

Reliability analyzes were based on item-level data from the independent rating sheets. In terms of inter-rater reliability, Pearson's *r* or intra-class coefficients (ICC) were not obtained given the sample size, and that respondents and raters were not fully crossed or nested. Neither of these tests can remove systematic coder deviations and can therefore underestimate the true reliability of ill-structured measurement designs (ISMDs) such as the one used for this study (Putka et al., 2008; Hallgren, 2012). The G estimation coefficient (Putka et al., 2008) was chosen to make up for the limited data and as a less biased reliability estimator. A G coefficient above 0.7 was considered acceptable. Internal consistency reliability was assessed using Cronbach's alpha (Cronbach, 1951). Alpha coefficients above 0.7 were considered acceptable (Streiner, 2003).

Validity

Face and content validity were assumed as adequate given the iterative feedback and input from experts, managers, and staff members. Other forms of measure validity were not considered given the scarcity of data.

Results

Service characteristics

All TAU and OD interviews were completed with no missing data. Only TAU teams were able to provide copies of their operational policies as OD teams were still in the process of developing their own; however, given the structure of the trial clusters, TAU policies were also taken to apply to OD teams. The average caseload per staff member was 25.8 service users (SD = 7.36, range = 20–40) for the OD teams and 29.8 (SD = 8.50, range = 25–45) for TAU teams. The mean staff for OD teams was 9.5 (SD = 3.08, range = 5–13) and for TAU teams was 13.8 (SD = 3.49, range = 10–19). Psychiatrists, psychiatric nurses, clinical psychologists, and psychotherapists were the most common professions and were all

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TABLE 1 Service characteristics.

	Open Dialogue (n=6)		Standard care (n=6)	
	$\bar{X}$ (Range)		$\overline{X}$ (Range)	
Employed staff (FTE and WTE)	9.50 (5–13)		13.82 (10–19)	
Caseload	$\bar{X}$ (SD)		$\overline{X}$ (SD)	
Team	220.83 (120.68)		503.33 (165.73)	
Individual	25.83 (7.36)		29.83 (8.50)	
	n	%	*n*	%
Service setup				
Integrated	5	83.3	0	0.0
Stand-alone	1	16.7	6	100.0
Staff roles				
Psychiatrists	6	100.0	6	100.0
Nurses	6	100.0	6	100.0
Nurse assistants	2	33.3	1	16.7
Psychologists	6	100.0	6	100.0
Occupational therapists	3	50.0	5	83.3
Social workers	3	50.0	4	66.7
Support workers	3	50.0	5	83.3
Peer support workers	6	100.0	1	16.7
Advocates/volunteers	0	0	1	16.7
Weekly team meetings	6	100.0	6	100.0
Supervision arrangements				
Individual	5	83.0	6	100.0
Group	6	100.0	3	50.0

employed across teams (n=6). Occupational therapists were employed by 83% (n=5) of TAU teams, whereas only in 50% of OD teams. Only one TAU team (8%) employed advocates. Nurse assistants were employed by 25% of the teams (n=3) altogether (Table 1).

Preliminary psychometric properties of the COM-FIDE measure

Reliability analysis

Item-level calculations of the G estimate of reliability suggested a potentially good inter-rater reliability across the measure. All but two items showed coefficients above 0.6, and 17 of the 32 items (53,1%) showed coefficients above 0.9 (Table 2). The item 'Flexibility of Response' had a reliability coefficient of 0.42 and the item "OD continued professional development" had a coefficient of 0, given its null variance (rate variance = 0.000, rater variance = 0.000, estimated variance of the combination of rate*rater interaction and residual effects = 2.298).

Internal consistency

Both the 25-item COM-FIDE scale and the 7-item OD addendum suggested potentially good internal consistency, with Cronbach's alpha coefficients of 0.90 on the overall COM-FIDE scale and 0.95 in the OD addendum (see Table 3 for subscale-specific coefficients). An item-level analysis was conducted to examine whether deleting any individual item would make important changes to the overall internal consistency of each scale. Results suggested little influence of any individual item on the total internal consistency of the 25-item COM-FIDE scale (coefficient change ranging from-0.002 to 0.01) and the 7-item OD addendum (range = −0.020–0.016).

When analyzed on a section level, all 5 sections appeared to have adequate internal consistency (Table 3). Results suggested little influence of any individual item on the total internal consistency of their respective section (coefficient increases ranging from 0.02 to 0.04 across sections); however, some items showed very small item-total correlations (minimum value of 0.3; Field, 2017). Further, some items were found to negatively correlate with their sub-samples. For instance, in the 'Team structure and culture' section, items 'Supervision' had a negative item-total correlation of-0.01 as did 'Training' and 'Staff roles', with coefficients of-0.25 and-0.29, respectively. Also, in the 'Access and engagement' section, item 'Flexibility of response' had a negative item-total correlation of-0.04. All other items had item-total correlation coefficients above 0.4.

Item scores

On an item level, 6 of the 25 COM-FIDE items (24%) had mean scores equal to or above 3.40 ('very good'); 14 items (56%) had scores between 2.80 and 3.39 ('good'); two items (8%) had scores between 2.40 and 2.79 ('acceptable'); and three items (12%) had scores below 2.39 ('poor'; Table 4).

TABLE 2 Inter-rater reliability of the COM-FIDE using the G estimate (n=24).

Item	G(0.200, 2)
COM-FIDE scale	0.992
Team structure and culture	
1. Team ethos and comprehensiveness	0.914
2. Staff training	0.868
3. Supervision	0.829
4. Staff roles	0.918
5. Team capacity	0.897
6. Routine outcome monitoring	0.952
7. Safety	0.896
8. Service-user involvement in co-production	0.944
Access and engagement	
1. Access to the service	0.927
2. Providing information	0.689
3. Prompt action	0.818
4. Identification of support systems	0.916
5. Flexibility of response	0.421
6. Assertive engagement	0.913
Delivery of care	
1. Continuity of care	0.896
2. Establishing clinical meetings	0.918
3. Collaborative decision making	0.950
4. Information sharing and communication	0.751
5. Service-user involvement in the delivery of care	0.829
6. Coordination of care	0.646
External support	
1. Service linkage	0.884
2. Community links (Practitioner level)	0.783
3. Community links (Support system)	0.929
4. Caregiver involvement and support	0.969
5. Discharge and aftercare	0.760
Open dialogue addendum	0.997
1. Transparency	0.929
2. Self-disclosure	0.970
3. Intervision frequency	0.990
4. Intervision content and structure	0.995
5. Team self-work	0.964
6. OD training	0.995
7. OD continued professional development	0.000

Standard of care (COM-FIDE score)

Overall, the mean COM-FIDE total score (i.e., excluding the OD addendum, as this dimension was only relevant to OD teams) across all 12 teams was 3.11 (SD = 0.38, range = 2.72–3.72), possibly suggesting 'good' fidelity to standard NHS care. When analyzed by model of care, the 6 OD teams had a mean COM-FIDE total score of 3.25 (SD = 0.38; range = 2.78–3.72), whereas the 6 TAU teams had a mean COM-FIDE total score of 2.97 (SD = 0.35, range = 2.72–3.66). Open dialogue teams had higher scores in all sections compared to TAU teams (Figure 2).

TABLE 3 Internal consistency of COM-FIDE subscales.

COM-FIDE subscale (n=24)	Internal consistency (Cronbach's alpha)
Team structure and culture	0.681
Access and engagement	0.677
Delivery of care	0.817
External support	0.713
Open Dialogue addendum	0.954

Overall, OD teams scored higher on most items. TAU teams scored higher than OD teams in 'co-production' (mean = 2.25, SD = 0.52), 'service capacity' (mean = 2.92, SD = 0.49) 'routine outcome measurement' (mean = 2.17, SD = 0.26), 'access to the service' (mean = 3.08, SD = 0.66), and 'prompt action' (mean = 3.58, SD = 0.58; Figure 3).

Open Dialogue fidelity

When focusing only on the 6 OD teams, three of the 6 teams (50%) showed 'very good' fidelity, 2 teams (33%) were in the 'good' range, and one team (17%) demonstrated 'acceptable' fidelity. On an item level, 4 of the 7 items (57.1%) had mean scores equal to or above 3.40 ('very good'); two items (14.2%) had scores between 2.80 and 3.39 ('good); and one item (14.2%) had scores between 2.40 and 2.79 ('acceptable'; Figure 4).

Discussion

The Community Mental Health Team Fidelity Scale

These preliminary findings suggest that COM-FIDE is a robust measure of program fidelity for crisis and continued community care teams aiming at integrating OD to their practice. This is in line with the findings on the CYPRESS measure (Gaffney, 2012), which was shown to be a robust measure for assessing MST fidelity. As noted by Waters et al. (2021) in a recent discussion paper, there are significant commonalities between COM-FIDE general scale and the CYPRESS scale. Both were developed by the same research group and designed to capture all core components of well-functioning community-based teams (in the case of CYPRESS, for services for children and young people). The design of COM-FIDE supports its use as a measure of fidelity for current standard community care (the comparator in many evaluations). In establishing the ODDESSI program, the research group drew a distinction between OD as an organizational intervention (i.e., fidelity) which is measured by the COM-FIDE measure, and a therapeutic intervention (i.e., adherence) which is measured by the OD Adherence Scale (Lotmore et al., 2022). While this approach will require additional reviews we believe this is more

TABLE 4 Differences in COM-FIDE mean scores between service models (n=12).

	Open Dialogue (n=6)		Standard care (n=6)	
	Mean (SD)	Range	Mean (SD)	Range
COM-FIDE score	3.25 (0.38)	2.78–3.72	2.97 (0.35)	2.72–3.66
Team structure and culture	3.02 (0.37)	2.56–3.44	2.99 (0.35)	2.63–3.63
Access and engagement	3.26 (0.40)	2.58–3.75	3.15 (0.44)	2.58–3.83
Delivery of care	3.35 (0.51)	2.67–4.00	2.65 (0.48)	2.17–3.50
External support	3.47 (0.34)	3.10–3.90	3.10 (0.44)	2.60–3.70
Open dialogue addendum	3.44 (0.36)	2.93–3.79	1.30 (0.30)	1.00–1.86

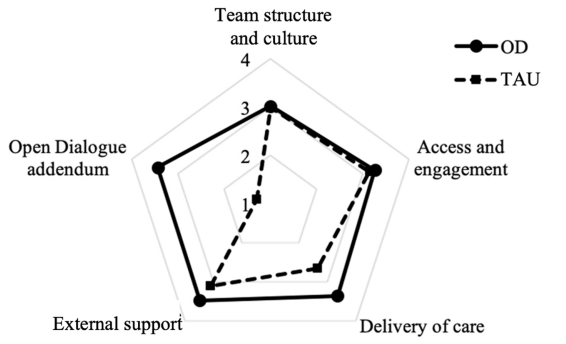

FIGURE 2
Comparison of mean COM-FIDE section scores between Open Dialogue (OD) and standard care (TAU).

than compensated for by allowing for the key organizational elements of OD and standard care to be robustly compared. The adherence measure is only of relevance for OD services.

In terms of reliability, inter-rater reliability is promising especially considering that none of the raters were OD-trained. Although three items of the general scale and one item from the OD addendum were below acceptable ranges, it is possible that this was a consequence of unclear behavioral anchors. Interestingly, both 'providing information' and 'coordination of care' received mixed feedback from experts. Developers argued that providing information about the service to clients and referrers helps streamline access to the service; however, there were some doubts on whether these two features were too similar to tease apart during interviews. Similarly, coordination of care was considered a key component of crisis and continued community care; however, there were concerns about this item being redundant. With regards to 'flexibility of response', the low reliability may have been due to the lack of clarity in the definition, which made it difficult for raters to reach a consensus in scores. As per the lack of inter-rater variance in the OD-specific item of "continued professional development," this may have been because all OD sites attended the same CPD programe and anchors were not sensitive enough to identify major differences in extended training beyond percentages of staff engagement. Future versions of the manual could include clearer definitions and more specific behavioral anchors.

In terms of validity, COM-FIDE appears to have adequate content validity and the ODDESSI team considered it feasible for use in the full trial. The iterative item refinement process, as well as the discussions with international experts in the field (including the developer of Open Dialogue) were central to developing items that would fit both models of care while also being sufficiently sensitive to possibly distinguish between them.

Defining a 'good' standard of care

Results suggest that all teams demonstrated a 'good' standard of care against the criteria set out above. Most OD teams developed from TAU teams (except for one team which was an independent team prior to the trial); with a varying degree of experience, staffing, and capacity across teams.

The four-tier cut-off approach was chosen as a solution based on existing literature on fidelity measurement. Although it proved useful in determining whether participating teams were ready for inclusion in the trial (i.e., 'acceptable' fidelity) it was limited in setting variations in fidelity above the cut-off. Further data collected across a range of OD and a range of community mental health teams should support further refinement of the scale.

Strengths and limitations

COM-FIDE is a feasible and reliable measure for use in the ODDESSI program and is the first measure to explicitly address service level delivery of open dialogue. Its development and results from the present study identified a number of strengths but also highlighted some limitations of the measure.

One of the main strengths of the study is in the measure development process. One of the aims of the ODDESSI trial was to comprehensively assess the organizational and therapeutic elements of OD by developing valid and reliable measures to compare OD versus current standard care. We believe this was best achieved through two distinct measures (i.e., COM-FIDE and OD Adherence Scale). Having the opportunity to discuss and revise the measure with experts in the field allowed for a rich discussion about the theoretical 'critical components' of the Finish OD approach to translate the therapeutic principles (Seikkula et al., 1995), and key elements (Olson et al., 2014; Ziedonis et al., 2015) into measurable structural and therapeutic variables. A modified Delphi approach to expert feedback (Dalkey and Helmer, 1963) may have nonetheless provided more structure to the measure development process.

In terms of limitations, a larger sample would have allowed for more robust methods (e.g., factor analysis); but as noted

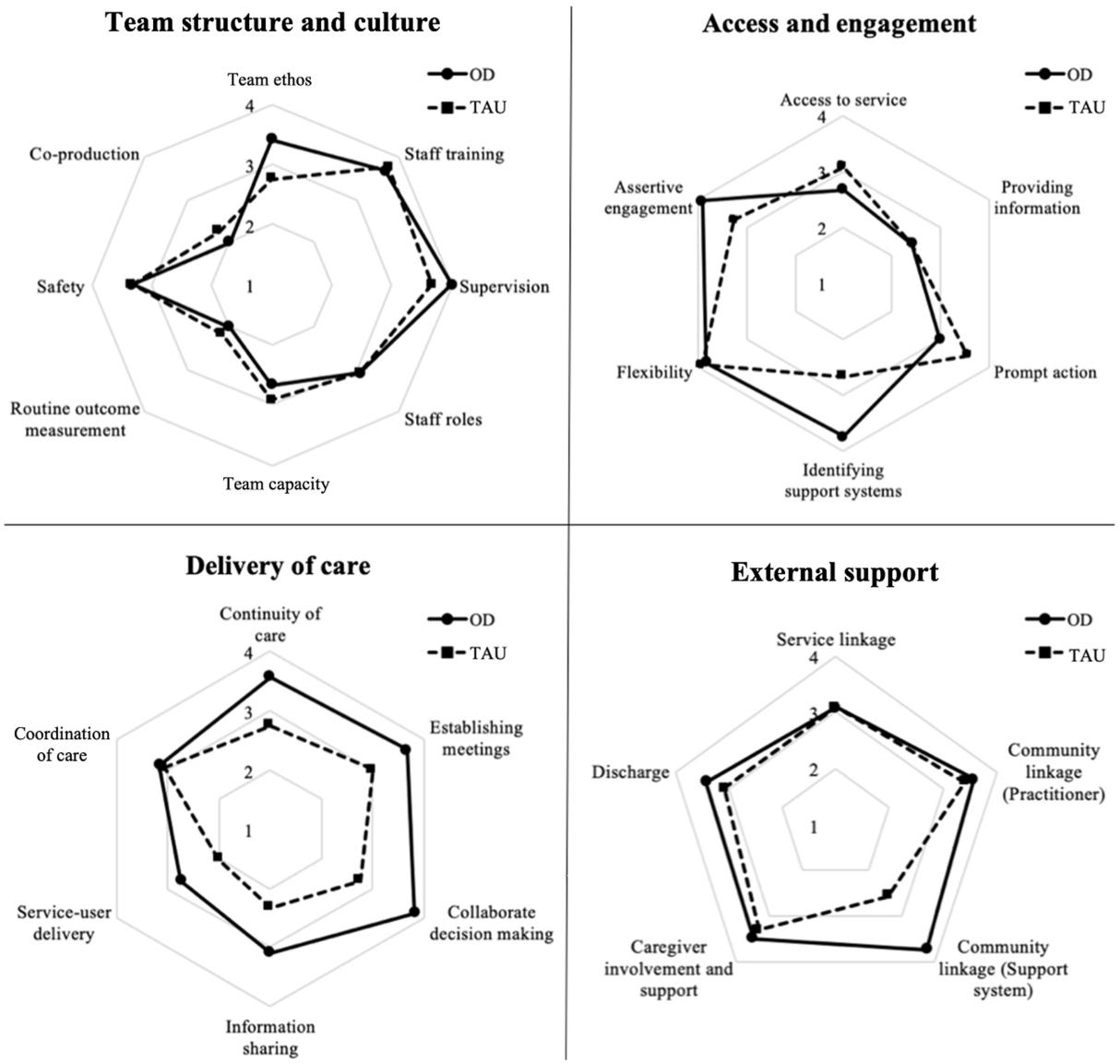

FIGURE 3
Comparison of mean COM-FIDE item scores between Open Dialogue (OD) and standard care (TAU).

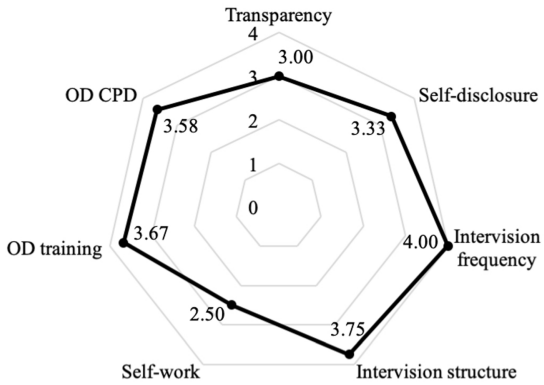

FIGURE 4
Mean scores of the Open Dialogue (OD) addendum (Open Dialogue teams). CPD=Continued professional development.

above this could be addressed when additional data becomes available. Another limitation was that raters were not fully crossed or nested given the difficulties in matching respondent and rater availability. This limitation was addressed in two ways: first, the G estimator–although unconventional–seemed a robust solution to this as it considers rater assortment and systematic rater deviations; and as interviews were recorded it is possible to further assess reliability using novel independent raters.

Conclusion

This paper describes the development, piloting, and testing of a program fidelity measure for its use in the ODDESSI program. The Community Mental Health Team Fidelity Scale (COM-FIDE) captures both standard NHS crisis care practice and open dialogue practice. The measure development process used recognized

methods including multiple raters, multiple data sources, and multiple settings to assess its properties. Preliminary psychometric results were encouraging, suggesting that COM-FIDE is suitable for use in a range of community mental health settings. Results suggest that COM-FIDE may be able to establish (a) the extent to which teams deliver their respective models according to their protocols, and (b) the degree of differentiation between similar approaches to crisis care and recovery.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving human participants were reviewed and approved by this study received ethics approval from the Health Research Authority under reference number 18/LO/0026. No personal or confidential information was solicited. Participants gave consent for being recorded using an encrypted and password-protected recorder. The patients/participants provided their written informed consent to participate in this study.

Author contributions

MA-M, ML, and SP contributed to conception and design of the study. MA-M organized the database, performed the statistical analysis, and wrote the first draft of the manuscript. All authors contributed to data collection, manuscript revision, read, and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Development of the peer-supported open dialogue attitude and competence inventory for practitioners: A Delphi study

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Introduction: Peer-supported Open Dialogue (POD) is a novel approach to mental health care that is currently being practiced and researched in the United Kingdom. For POD to be successfully implemented, effective training must be provided to make sure trainees are prepared to deliver the approach as intended. Therefore, a specific instrument that can assess the development and competence of POD trainees, as well as the effectiveness of POD training is crucial. Therefore, the current study aimed to establish an inventory named the *Peer-supported Open Dialogue Attitude and Competence Inventory* (PODACI), measuring the changes in attributes and attitudes of trainees before and after training.

Methods and Results: To generate the inventory, a four-round modified Delphi approach was used. We first identified the dimensions that are essential and specific to POD through an extensive literature review and individual interviews with practitioners (n=8). After generating the items, we further refined the items through two rounds of questionnaires, asking practitioners to rate the relevance of each item from 1 (not essential) to 4 (highly essential; n=21 and n=10), and finalized the inventory *via* a focus group interview with POD trainers (n=4). In total, 76 items were included in the PODACI. A good consensus on the items was reached: the median score of the items was all above 3.00 (essential) and achieved an agreement level greater than 85%. The Kendall coordination coefficient W was 0.36 and 0.28 in the two questionnaires employed, indicating a fair level of agreement between participants.

Discussion: The PODACI provides a way to measure attitudinal and competency factors related to the treatment integrity of POD as well as the efficacy of the training courses being offered. This highly enriched instrument opens up a wide range of possibilities for POD research and application, facilitating the development of Open Dialogue services. The next step is to assess the psychometric properties of the inventory.

KEYWORDS

open dialogue approach, peer-supported open dialogue, Delphi method, inventory, PODACI, interviews, questionnaires

1. Introduction

Open Dialogue (OD) is a novel approach to mental health care that embodies systematic family therapy, delivering a distinct form of therapeutic dialogue (Seikkula et al., 2006). For OD, the main aim of the clinicians is the creation of a common understanding of a presented difficulty through shared language, rather than problem-solving. OD is based on the principle that both the clients and clinicians are people with their own experiences, and when they are able to work collaboratively, can help achieve an understanding of the situation. The engagement of every party in the treatment and the transparent nature of therapy planning is what the term *open* refers to Olson et al. (2014). To encourage free exchange and break down the clinician-'patient' boundary, OD focuses on *dialogue* both as a method of therapy and a system of care. For a network meeting (i.e., meeting with the client and their social network) to be dialogical, it needs to be based on the client's own input rather than the agenda or specific targets of the clinicians. Therefore, clinicians need to have two essential skills to successfully practice dialogical therapy: the skill of responding and the ability to reflect. The former requires the clinician to pay attention to the utterances given by the client, the network members, and even themselves. The latter refers to the ability to reflect on the topics and the clinician's own feelings that emerge in a meeting. These person-centered meetings facilitate listening, invite all voices to be heard, and construct meaning through seeing, hearing, and feeling all those present. It has been argued that only through a dialogical approach can one explore possible traumas that are often the root cause of severe symptoms of a mental health crisis (Olson et al., 2014). While OD incorporates principles of family therapy (i.e., adopt a network-wide exploration), it does not focus on the family system or the communicative patterns among the family (Seikkula, 2003) *per se*: OD does not aim to change the fixed dynamic of a system, but rather to create a joint space for new language, facilitating the production of different meanings for the particular difficulty (Seikkula, 2003). It is such features that differentiated OD from family therapy. Open Dialogue is also seen as a foundational framework for organizing and delivering help, involving the network, and creating a polyphony of voices at the point of initial contact with services, rather than an additional, time-limited intervention as is often the case with family therapy (Jackson and Thorley, 2021).

So far, there has been a growing body of supporting evidence for the application of OD. One of the first studies looking at OD's effect on the treatment of first-episode psychosis came from Finland. Seikkula et al. (2006, 2011) reported that 70% of participants treated *via* the OD approach returned to their studies and work, with 82% showing no residual psychotic symptoms. Positive outcomes were still present even after 5 years, where the OD group ($n = 42$) had a smaller duration of untreated psychosis, reduced medication use, and fewer days in the hospital compared to the control group. The benefits of OD have also been consistently demonstrated in more recent studies across the world, including Finland (Granö et al., 2016; Bergström et al., 2018), United States (Gordon et al., 2016; Rosen and Stoklosa, 2016; Freeman et al., 2019; Gidugu et al., 2021), Denmark (Buus et al., 2019), and Australia (Dawson et al., 2021).

1.1. Open dialogue in the United Kingdom: Peer-supported open dialogue

Following the successful implementations of OD around the world, practitioners and researchers in the United Kingdom started to explore the practicality of a novel OD model: Peer-supported Open Dialogue (POD) (Razzaque and Stockmann, 2016). Besides OD's fundamental principles (Seikkula et al., 2006; Olson et al., 2014), POD also involves peer workers with experiences of mental health services and are qualified to enhance the democratic nature of the POD meetings. Although the National Health Services (NHS) in the United Kingdom has a limited amount of POD services at the present, there is an actively growing interest in the approach. For instance, the ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) is a large-scale program that is currently taking place in the country (runs from 2017–2022 but delayed due to COVID-19; Pilling et al., 2022). The program aims to assess the effectiveness, acceptability, and ability to implement POD into the NHS services. In line with the ODDESSI, several small-scale qualitative studies have revealed that POD allowed the clients to build a more equal relationship with their practitioners and made them feel listened to and acknowledged (Tribe et al., 2019; Hendy and Pearson, 2020; Twamley et al., 2021; Kinane et al., 2022).

Despite the positive evidence on POD, it is uncertain whether the approach can be implemented successfully in the NHS. Since the NHS is biomedically founded, emphasizing specific standards such as the risk management of each client (McKeown et al., 2015a,b) and medication as a possible solution of a 'mental illness' (Elliott et al., 2018), its focus differs from the core principles of POD. POD values a more unifying approach to mental health care, aiming to develop dialogical communication between the patient and their support system as a therapeutic intervention (Razzaque and Wood, 2015), and considering a wide range of factors and solutions that are primarily directed by the client. This difference is vital, as it changes the focus of the therapeutic meeting, but most importantly how people deliver mental health care and how future practitioners are trained. Indeed, identified by Razzaque and Wood (2015), POD practitioners themselves argued that implementing POD would be challenging due to (1) major cultural shifts from the medical-based treatment as usual (TAU) to a more person-centered, holistic, relational, and compassionate approach in POD (e.g., relying less on particular diagnosis, set procedures, and medical prescriptions, and putting more emphasis on collaborative decision making, hearing the voices of all present and creating a sense of safety so that all stories can be heard (Jackson and Thorley, 2021) (2) professional changes in current practitioners' approach to mental health (e.g., surrendering one's power and positive risk taking; Razzaque and Wood, 2015). While many clinicians embrace the possibility of creating a less oppressive medicalised service, challenging existing hierarchies within existing services is not easy (Tribe et al., 2019; Dawson et al., 2021). For individual practitioners, POD trainings can be difficult and somewhat uncomfortable as trainees are expected to work as part of a non-hierarchical team, share relevant aspects of their own life histories and display their emotional vulnerability (Schubert et al., 2021), which some of them described as almost a 'cult-like culture' (Florence et al., 2020). To narrow the cultural gap and help clinicians adapt to the changes, it is essential

for them to receive effective and adequate training to practice POD efficiently.

1.2. Peer-supported open dialogue training

In POD, training plays a vital role in helping professionals to make necessary changes in their day-to-day practices, learn the key fundamentals of the approach, and deliver POD effectively, especially when they have been previously trained in different practices.

Currently, a one-year POD training course is being offered in the U.K. The training has now been running for almost 8 years (since October 2014) with hundreds of practitioners. The course consists of four residential weeks that are spread over the year and involves trainers from five different countries, including many of OD's founders like Professor Jaakko Seikkula. To assess the efficiency of the training, Stockmann et al. (2019) conducted four focus group interviews with 27 trainees who completed the POD course. They found that the trainees reported the training as an emotional journey, which helped them to change their attitudes and approach to clinical work. In particular, POD training was considered to 're-humanise' mental health practice compared to TAU, encouraging clinicians to be more authentic. The findings suggested that POD training promoted a different mindset that was almost inconceivable for participants who came from entirely different clinical backgrounds.

1.3. Treatment integrity in peer-supported open dialogue

One of the primary goals of professional training is to ensure treatment integrity. Treatment integrity is defined as "the degree to which treatment is delivered as intended" (Yeaton and Sechrest, 1981, 1992). Treatment integrity of an approach is also found to be positively correlated with the psychotherapy outcomes (Barber et al., 2007). Hence, any approach to mental health care should be able to be assessed with regards to the integrity of its implementation. Otherwise, the validity of treatment outcomes becomes limited, making it difficult to conclude the efficacy of the approach (Waltz et al., 1993).

Intervention integrity is often broken down into two overlapping but distinct areas: fidelity and adherence. The term fidelity is used to describe interventions at multiple levels including measures of systems implementation, service provision and operational principles, while adherence is used to describe the degree to which a practitioner delivers an intervention in accordance with theoretical and procedural elements of the model (Hogue et al., 1998). Adherence is closely related and often differentiated from the concept of therapist competence which can be defined as the internalization and integration of attitudes, knowledge, motives, beliefs, empathy, relational understanding, clinical reasoning, emotions, values, and critical self-reflection relevant to their practice (Epstein and Hundert, 2002; Baartman and de Bruijn, 2011; Perepletchikova, 2014; Cox et al., 2019; Crameri et al., 2020). In this sense, competence is what contributes to successful practice (Antera, 2021). Therapist competence captures important therapy process variables which have been shown to impact the therapist-patient alliance as well as treatment outcomes (Norcross and Wampold, 2011; Wampold, 2015).

Hence, any approach to mental health care should have the ability to assess a broad range of factors, including the competence and attitudes of the practitioners prior to using the approach. Otherwise, the validity of treatment outcomes becomes limited, making it difficult to conclude the efficacy of the approach (Waltz et al., 1993). In the ODDESSI trial, the fidelity of service delivery was measured using the COM-FIDE instrument (Alvarez Monjaras, 2019) and adherence was measured using the Open Dialogue Adherence Scale (Lotmore, 2019; Lotmore et al., 2023), but no instrument was included in the trial to measure competence.

Various mental health interventions have developed instruments to measure their practitioners' or trainees' competence. These instruments often took the form of scales that measure particular attributes (Grove et al., 2012), questionnaires that record knowledge and opinions, or inventories that are catalogues of different attributes, attitudes, and perceptions (Younas, 2017). For instance, researchers following the cognitive behavioral therapy (CBT) approach had developed multiple scales to measure treatment integrity, including but not limited to the Cognitive Therapy Scale (CTS; Vallis et al., 1986) and the 21-item Cognitive Therapy Adherence and Competence Scale (CTACS, Barber et al., 2003). A higher score on CTS was found to be associated with a greater decrease in the severity of clients' depressive symptoms and anxiety after treatment, indicating that practitioners with greater treatment integrity delivered more effective treatment (Trepka et al., 2004; Strunk et al., 2010). The evidence suggested that instruments measuring treatment integrity offer a quantitative way to examine the effect of training and to decide whether the practitioners were readily trained, which is essential and beneficial for successful deliveries of the appropriate treatments.

Compared to interventions like CBT, POD is a newly emerged approach that needs more attention and research. OD is considered to be a 'complex intervention' due to the inclusion of several interacting components that are necessary for delivering a desired outcome (Lotmore, 2019). Before joining the POD course, every trainee has different starting points, experiences, and beliefs, so their journey throughout the training would vary individually. While some may find the training to be life-changing and are prepared to practice POD right away (Dawson et al., 2021), others may need more time to gain a better grasp of how to practice POD. Therefore, it is necessary to develop an instrument that assesses the development and competence of trainees before and after training (e.g., how well the trainee has internalized and integrated attitudes, knowledge, values, etc. relevant to their practice), further examining the integrity of POD delivery, as well as advancing our understanding of the efficacy of POD and facilitating its wider implementation.

1.4. Current study

The current study aimed to develop a self-report inventory called the *Peer-supported Open Dialogue Attitude and Competence Inventory* (PODACI). The inventory intended to examine (1) a trainee's competence after training based on their attitudes and

attributes and (2) the effectiveness of the POD training that is currently provided. To generate the inventory, we adapted a four-round modified Delphi procedure that combined a literature review, "expert" opinions, and group consensus through structured interviews and questionnaires (Joling et al., 2017; Keeney et al., 2017; Mao et al., 2020). The Delphi process has been shown to be highly effective in collecting data (Graefe and Armstrong, 2011), and well suited for areas with incomplete knowledge like POD (Skulmoski et al., 2007; Fink-Hafner et al., 2019). The procedure could strengthen the validity of the inventory with the inclusion of POD practitioners, trainers of the POD course, and current trainees. In this study, we first identified items that are specifically unique to POD through an extensive literature search and detailed discussion with POD practitioners, and then further refined the items through two rounds of questionnaires and one round of focus group interview.

2. Item generation

The first stage of the current study generated the initial sets of items through an extensive literature review as well as individual interviews with POD practitioners and trainers (i.e., Round One of the Delphi procedure).

2.1. Literature review

Before beginning the Delphi procedure, a literature search was carried out *via* online databases (e.g., PubMed, Google, and Google Scholar) reviewing the structure of POD, the reported competencies in delivering the approach, and other existing published scales relevant to Open Dialogue (See Appendix A for a categorical list of the papers and books reviewed). With the information obtained, we formed 10 potential domains on the attributes and attitudes relevant to what POD trainees should have (see Table 1). Most of these dimensions were formed under the seven principles of open dialogue created by Seikkula et al.'s (1995) team as overarching guidelines for delivering an open dialogue meeting.

2.2. Delphi round one: Interviews

As POD is a relatively new area of research, to identify the domains that are not well reported in the literature, the first round of the Delphi began with a series of semi-structured interviews.

2.2.1. Participants

Eight POD practitioners that were either trainers of the POD training program or part of the Dialogue First team (Dialogue First is a non-crisis community mental health service operating in accordance with the key principles of OD within North East London NHS Foundation Trust) were invited as experts for the individual interviews (5 female) through their individual emails. The age of the interviewees ranged from 36 to 70 years (mean = 51.3 years, SD = 9.92). All the participants were from England, and their professional roles included one or more of the following: POD trainer (4), academics (3), systematic family psychotherapist (2), consultant psychologist (1), peer-support worker (2), mental health nurse (1), art therapist (1). On average, their duration of service with POD was 6.13 years (SD = 5.28).

The ethical approval of the present study is covered by the ODDESSI project, and all participants were informed that their involvement was voluntary and explicitly gave consent.

2.2.2. Procedure and results

During the interview, we first provided a brief background of the current study to the practitioners. Afterward, the practitioners were asked three questions: (1) "What initially got you interested in Open Dialogue?," (2) "Were there any changes that you experienced throughout training?," (3) "What do you think should be considered as a measure of competence or attitude change?." The structure of the interviews was flexible, so the nature of the follow-up questions differed between participants. In general, the interviews lasted 30 min to 1 hour. The interviews were recorded when the practitioners gave permission.

We manually transcribed and interpreted the interview content through a standardized thematic analysis by identifying and forming patterns of themes within the interview data (Braun and Clarke, 2006). Areas of the transcripts directed toward the PODACI or potential POD competencies were extracted and grouped in two separate documents. Rather than approaching the data with a

TABLE 1 Ten attitude and attribute dimensions derived from the literature background and their definition.

Attitude Dimensions	
POD Principles:	Attitudes people have toward the main principles of POD, e.g., tolerating uncertainty
Peer-support role:	Acknowledging the importance of peers
POD agenda:	Agreeing that no particular objectives or plans should be made prior to meeting the client
Political and social influence:	Understanding that real-world problems, e.g., social factors may interplay with a client's well-being.
Attribute Dimension	
A humanistic view:	Being able to talk to a client as a human with experiences rather than an 'expert'
Trust:	Being a person that is comfortable in forming relationships and trusting others is vital.
Being present:	Not over-analyzing and offering more voice and priority toward the client.
Emotional Awareness:	Acknowledging and accepting client's emotions is crucial.
Emotional Intelligence:	Having the ability to emphasize with client's emotions and understand them.
Importance of Dialogue:	A mental health worker's primary aim is to create space for dialogue.

TABLE 2 Twenty attitude and attribute dimensions obtained from the interview and their definition.

Attitude Dimensions	
Trauma-informed approach:	Understanding the importance of Trauma in shaping a client's behavior.
Family Importance:	Acknowledging the importance, a family in therapeutic context.
Losing the 'expert role':	Being aware of the power one has over a client, and how influential words are.
'Nothing about them, without them':	All discussions and plans are to be done with the client.
Personal Development:	Having a critical understanding of your own background is crucial for mental health care.
Recovery:	Understanding that recovery is a unique process that needs to acknowledge in its own way.
Client-centeredness:	All the therapy plans, and meetings should be based on the client's input.
Tolerating uncertainty:	Experiencing silence between the mental health worker and the client has its therapeutic benefits.
Attribute Dimension	
Self-Disclosure:	Being comfortable in sharing one's experiences to the client.
Awareness of Self-bias:	Having awareness of the prejudice and bias that one may hold.
When and What to Disclose:	Knowing when it is the right time to disclose personal information and experiences.
Active listening:	Having the ability to listen and response accordingly.
Mindfulness:	Paying attention to one's own emotions, ideas and behaviors.
Empathy:	Acknowledging and accepting a client's emotional status.
Accepting:	Viewing clients for who they are, and not based on their diagnosis.
Open to emotions:	Transparent with one's own emotions and others.
Self-Compassion:	Being warm and understanding toward ourselves when we suffer, rather than ignoring our pain.
Relationship Confidence:	Feeling confident in forming new connections and bonding with new people.
Reflective of Self:	Open to feedback from both colleagues and clients.
Compassion:	Recognize the suffering of others and take action to help.

pre-determined notion, we were guided by inducting reasoning and recognized common themes based on similarity, leading to the formation of 20 more domains for the PODACI (see Table 2 for the additional dimensions obtained from the interviews).

Based on the dimensions formed, we constructed items to measure each of the areas. The items would ask the trainees to rate the extent to which they agree with certain statements, from 1 (strongly disagree) to 5 (strongly agree). For example, an attribute domain like mindfulness could contain the item: 'I pay attention to how my emotions affect my thoughts and behavior when talking with clients. How far do you agree?'. In addition, we generated reverse worded (RW) items to reduce acquiescence bias, which is the respondents' tendency to agree with a given item regardless of its content (Zhang et al., 2016). RW items are expected to be scored lower by POD practitioners but higher with TAU professionals. For example, "I have feelings that I cannot quite identify when talking to a client" is a RW item against the attribute of mindfulness that all POD trainees should have, whereas TAU practitioners may not value as much.

In total, the first draft of the PODACI contained 30 dimensions with 167 items. The items in the draft were then assessed in the following rounds to validate their importance.

3. Item refinement

The second stage of the study refined the initial set of items through two rounds of questionnaires (the second the third round of Delphi) distributed to POD practitioners.

3.1. Delphi round two: First questionnaire

In Round Two, POD practitioners were asked to rate the importance of the 167 items generated in the first stage of the procedure, and their responses were used to refine the draft of PODACI.

3.1.1. Participants

Twenty-one participants were recruited *via* an open invitation sent through the POD mailing list of the ODDESSI project. We did not set a specific selection criterion for this round as we aimed to include opinions toward the approach and training from practitioners at various stages of experience with POD. Among the participants, thirteen completed the whole round (completion rate of 65.63%), and eight dropped out in different areas of the questionnaire (data was still included). Each of the participants had either completed the POD training course prior to the study or was a trainee nearing the completion of training. Table 3 summarizes the demographic information of the participants.

3.1.2. Procedure

The experiment was presented in a web browser using Gorilla[1] (Anwyl-Irvine et al., 2020). After giving consent, participants were asked to provide some basic demographic information about themselves, including their gender, age, country/region of residence, professional

1 www.gorilla.sc

10.3389/fpsyg.2023.1059103

TABLE 3 The demographic information of the participants in round two of Delphi, including gender, age, region of residence, professional role, and duration of service with POD.

Female gender	*n* %
	14 (66.6%)
Age	
21–30	3 (14.3%)
31–40	5 (23.8%)
41–50	6 (28.6%)
51–60	6 (28.6%)
Over 60	1 (4.76%)
Region of residence	
England	16 (76.2%)
Netherlands	3 (14.3%)
Ireland	1 (4.76%)
Wales	1 (4.76%)
Professional Role	
Academics	1 (4.76%)
Systematic family psychotherapist	1 (4.76%)
Consultant psychologists	1 (4.76%)
Peer-support worker	4 (19.1%)
Mental health nurse	3 (14.3%)
Mental health social worker	4 (19.1%)
Speech and language therapist	1 (4.76%)
Clinical psychologist	1 (4.76%)
Psychiatrists	2 (9.52%)
Doctors	1 (4.76%)
Case manager	1 (4.76%)
NHS keyworker	1 (4.76%)
Current POD trainees	3 (14.3%)
POD service time in years, mean (sd)	2.59 (1.35)

The percentage for professional roles goes above 100% because each POD practitioner has several roles.

background/role, completion of POD training, and years of services in POD. Participants were then provided with basic information about the PODACI inventory and what the items aimed to measure.

Following the instruction, the participants were presented with one item on each page and asked to rate how essential they think the item was using a 4-point Likert scale (from 1 = not essential to 4 = highly essential). Under the Likert scale, a text box was also provided for comments, questions, and suggestions. An example of how an item was presented can be found in Figure 1. At the end of the experiment, participants were given two optional open questions that asked whether the POD training changes them and what they think should be measured in PODACI.

3.1.3. Analyses and results

3.1.3.1. Ratings

To evaluate the consensus for each item, we calculated the median, interquartile range, and agreement level of the ratings for each item. An item was considered suitable and remained in the PODACI draft if it satisfied the following criteria: (1) the median of participants' ratings for that item must be 3.00 or above (Mao et al., 2020), ensuring that each item is rated on a minimum of essential or higher; (2) the interquartile range must below 1.00 to indicate an agreement among the group (Raskin, 1994; Rayens and Hahn, 2000); and (3) the level of agreement must reach 85% or above. Items rated in the range of 70 to 84.9% were reconsidered in the Round 3 questionnaire, and those below a 70% rating were rejected (Mao et al., 2020; Mitchell et al., 2021). In addition, the Kendall coefficient of concordance was calculated through SPSS (IBM Corp. Released, 2019, IBM SPSS Statistics for Windows Version 26.0.) to evaluate the consensus agreement among participants (Mao et al., 2020).

Based on the criteria above, we accepted 74 items, 22 items were sent to Round Three to be reconsidered, and 71 items were deleted (see Appendix B for a detailed summary of the statistics for each item). The Kendall coefficient of concordance (W) was calculated to be 0.36 ($p < 0.01$), which indicates a fairly significant level of consensus among the participants.

3.1.3.2. Open comments and questions

We manually recorded and analyzed the comments provided in the textbox for each item as well as the open question at the end of the questionnaire.

The data on the comment text box included 117 specific comments for 41 items in the attitude section and 112 comments for 71 items in the attribution section. Based on the comments, changes were made to 13 attitude items and 3 attribute items – most modifications were regarding the wording and definitions of the items as well as grammar adjustments. One item that previously fit the reconsideration criteria of ratings was also deleted due to the confusion presented in the feedback. Furthermore, while many of the reversed scored items did not meet the criteria for consensus, it can be argued that most scores given to reverse items were misinterpreted. For example, a comment for the reverse item "A professional should avoid talking about trauma unless brought up by the patient themselves" stated: "always talk about trauma if the patient has the need. Not sure if I had to score 1 or 4." Although this participant acknowledged the importance of trauma in POD, they scored the item as 1 (non-essential) due to confusion. To compensate for this misunderstanding, seven reversed items with positive comments were reformulated as non-reverse items to be reconsidered in the next round.

Based on the responses to the open questions, we generated five more themes. Since some of the new themes overlapped with the more general topics in the pre-existing themes, we only formed two novel items for re-testing in the third round.

In total, our results suggested that 30 items needed to be reconsidered in Round Three (21 items from the ratings, 7 novel non-reverse items, and 2 items from the open questions).

3.2. Delphi round three: Second questionnaire

The third round consisted of a new questionnaire that measured the relevance of 30 items that were deemed necessary to be re-tested.

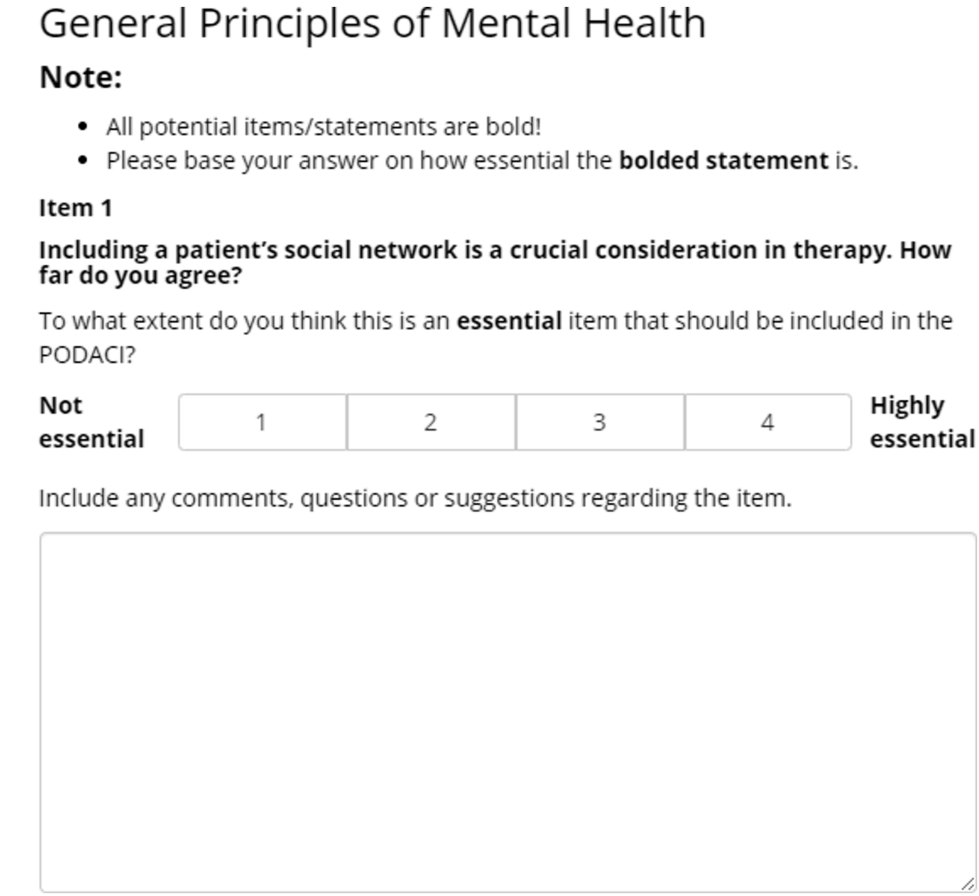

FIGURE 1
An example of the presentation of an item and the scale.

3.2.1. Participants

We contacted the 13 participants who had completed the second round for further re-testing and 10 participants responded (8 female). The age of the participants ranged from 29 to 60 years (mean = 45.78 years, SD = 12.22). All the participants are from England, and their professional roles included peer-support worker (3), mental health nurse (4), social worker (1), clinical psychologist (1), and speech and language therapist (1). Three of the participants were current POD trainees, and on average, their duration of service with POD was 1.44 years (SD = 1.22).

3.2.2. Procedure

The procedure followed that of round two (first questionnaire). The practitioners rated how essential the items were based on the 4-point Likert scale. Uniquely to round three, each item was presented with a group aggregated rating based on the previous round to promote more consideration in the individual's answers.

3.2.3. Analyses and results

Using the same consensus criteria as round two, the reconsidered items were either accepted (85% agreement level or above) or deleted (anything below 85% agreement level), as there were no more rounds for re-assessment. The Kendall coefficient of concordance was also calculated.

Overall, the Kendal coefficient of concordance (W) for this round was 0.28 ($p < 0.01$), indicating a fairly significant level of group consensus. Three items were deleted because they did not satisfy the consensus criteria and 27 items were accepted and added to the PODACI draft (see Appendix C for a detailed summary of the statistics for each item).

In total, the second draft of the PODACI now contained 102 items (75 items from round two and 27 items from round three).

4. Inventory finalization

4.1. Delphi round four: Group interview

The fourth and final round of our Delphi procedure aimed to finalize the structure and content of the PODACI through a focus group interview with POD trainers as they have extensive experiences with the training program's goals, procedure, and its effect on trainees (some participated in the previous rounds).

4.1.1. Participants

Four POD trainers were invited to the group interview (3 participated in the first round, 2 female). The age range of the trainees was from 49 to 70 years (mean = 58.5 years, *SD* = 8.66). Three of the

trainers resided in England and one was from Norway. Their professional role included one or more of the following; POD trainers (4), academics (1), systematic family psychotherapist (2), and consultant psychologists (1). The trainers' average duration of POD service was 13.5 years (SD = 5.26).

4.1.2. Procedure and results

Before the interview, the panelists had to complete a questionnaire based on the second draft of the PODACI. The questionnaire asked the panelists to rate how essential each item was on a four-point Likert scale similar to round two and three. There were no open-based questions or group aggregated ratings. Items that received a median rating of 3.5 and a level of agreement above 85% were automatically kept in PODACI. Any items whose ratings did not reach a median of 3.50 and a level of agreement between 85 and 100% were discussed in the group interview for further clarification. Items with a median rating below 2.00 were removed. A higher selection criterion (i.e., median rating above 3.50) was necessary to identify any minor discrepancies within items.

Based on the ratings in the questionnaire, a word document was made of items that required clarification and sent to the participants. During the focus group interview, we read out the items of interest, and the group covered any emerging differences of opinions. Once a verbal agreement was evident on a particular item, the feedback was applied to the PODACI, forming the final draft of the inventory.

Findings from the fourth round of questionnaires identified 49 items that met the consensus criteria, six items that were removed due to a low score, and 47 items considered for further discussion in the group interview (see Appendix D for detailed statistics for each item). The Kendal coefficient of concordance (W) for the questionnaire was 0.54 ($p < 0.01$), indicating a strong agreement. Based on the group meeting on the 47 reconsidered items, 19 items were changed, 20 items were deleted, and eight items remained. In total, the final version of the PODACI contained 76 items summarized in Table 4.

5. Discussion

The present study aimed to create an inventory that can assess how prepared POD trainees are and the efficacy of the training course. With a four-round modified Delphi procedure, the current study generated the PODACI with 76 items.

All the items included in PODACI had a good consensus with a median range score of 3.00 or above in round two and round three and 3.50 or above in round four, an interquartile range from 0.00 to 1.00, and an agreement level over 85%. The Kendall coefficient of concordance (W) used to assess the agreement among the participants (Gearhart et al., 2013) was 0.36 in round two, 0.28 in round three, and 0.54 in round four, which showed fair to good level of agreement among participants (Gearhart et al., 2013; Mao et al., 2020).

The items in the PODACI have been specifically tailored to what POD trainees should present at the end of training. Specifically, the PODACI covered the 12 key elements of fidelity to dialogic practice (Olson et al., 2014), a wide range of attitudes toward the general principles of POD (Seikkula et al., 1995), as well as factors like peer-support and mindfulness that were reported to be essential in practice (Hopfenbeck, 2015; Razzaque and Stockmann, 2016; Jackson and Thorley, 2021). This highly enriched instrument opens up for a wide range of possibilities for POD research and application within and outside of the United Kingdom, as discussed below.

First, the PODACI provided a way to measure attitudinal and competency factors related to the treatment integrity of POD. With the instrument, OD researchers and trainers can examine the developmental changes within individual trainees, ensuring they have developed the necessary competence and attitudes to deliver POD as intended. In addition, PODACI offers the potential for large-scale studies with quantitative data that may be more reliable and comparable with pre-existing findings around the world. Practically, the quantitative research made available by the PODACI may generate straightforward evidence on the benefits of the POD training that can be presented to the service development managers and policymakers. Combining PODACI with previous qualitative studies could offer a more comprehensive view of POD training to the NHS, promoting the implementation of POD in the system.

Second, the PODACI could facilitate the development of training courses provided to future POD practitioners. At the moment, there were no available tools or procedures to systematically examine the efficacy of the training, so whether the courses were enough for trainees to practice POD appropriately was unclear. Examining POD trainees' responses to PODACI before and after training could (1) show which OD dimensions the training helped to improve the most or the least on a group level, and (2) inform the trainers what may be harder or easier to apprehend for each individual trainee. This information provided by PODACI could be used to advance the courses in general and to modify the training base on individual needs, which could lead to better trained practitioners.

Last but not the least, PODACI could be generalized to areas outside of POD as it covers a wide range of values and attributes necessary for general mental health practice. Within the United Kingdom, the NHS has presented a long-term forward plan (Alderwick and Dixon, 2019) that aims to review and advance the competencies of all mental health treatments available. PODACI could be used as a format for therapy approaches that shares some of the same essential qualities as POD to develop inventories in treatment integrity, such as systematic family therapy. In this way, practitioners could also compare various training schemes in family therapy, identifying the benefits and disadvantages of each and improve them accordingly.

While we need to acknowledge that the current study has a relatively small sample size, all of our participants are highly knowledgeable in POD and POD training. In a Delphi study, one of the most important considerations in sample collection is the selection of participants who are knowledgeable in the field of the study (Grisham, 2009). Skulmoski et al. (2007) validated the stability of response characteristics in a small panel and argued that a limited number of experts with similar training and knowledge would still yield reliable results, which is the case of the current study. Furthermore, more than half of the practitioners spent over 2 hours completing the two rounds of questionnaires (estimated time of completion is around 30–40 min), and the majority of interviews lasted as long as an hour, indicating that the panelists in this study were motivated in giving their best effort to help the development of

TABLE 4 The final version of PODACI.

Peer-supported open dialogue attitude and competence inventory (PODACI)
Attitude dimensions
General principles of mental health care
1. Clients should always be allowed to invite their social network to their meetings. How far do you agree?
2. Having the same team offer continuous care to a client over months and potentially years is more effective than care that is delivered consecutively by multiple specialized teams. How far do you agree?
3. The client should generally be allowed to decide the timing of the next meeting. How far do you agree?
4. Most of what is considered symptoms of mental illness, is actually meaningful behavior. How far do you agree?
5. The primary goal of mental health care should be to increase the agency of the client. How far do you agree?
6. The help offered should be dictated by the needs of the client. How far do you agree?
7. Being open about your feelings and experiences is a necessary skill in mental health treatment. How far do you agree?
8. Mental health care should place emphasis on the client's words and emotions present in the meeting, rather than the diagnosis, when considering treatment and medication. How far do you agree?
Trauma
9. Clients should be supported to talk about the possible role of trauma, abuse, and neglect in the development of their mental health issues. How far do you agree?
10. What has happened to a client shapes their mental health wellbeing in later life. How far do you agree?
11. The way most mental health services are currently delivered can easily be re-traumatizing for clients. How far do you agree?
12. Most of what is diagnosed as mental illness is the result of trauma. How far do you agree?
Recovery
13. For some forms of mental illness, recovery is not possible. How far do you agree? (REVERSE)
14. Experiencing setbacks is a normal part of a client's recovery. How far do you agree?
15. Clients have different ways in how they recover from mental illnesses. How far do you agree?
16. All people with serious mental illnesses can strive for recovery. How far do you agree?
17. Clients are 'experts by experience' who play the most important role in their own recovery. How far do you agree?
Client-centeredness
18. One of the practitioner's main function is to try to convey to the client that they are listening and are accepting of the client's feelings and attitudes. How far do you agree?
19. A specific and thorough diagnosis is essential for effective outcomes in mental health care. How far do you agree? (REVERSE)
20. When in a meeting with a client, what is important is your ability to 'be with them' rather than 'doing something to them'. How far do you agree?
Tolerating silence and uncertainty
21. Tolerating silence or uncertainty in a client meeting can lead to beneficial outcomes. How far do you agree?
22. If a client wishes to spend time in silence, they should be allowed. How far do you agree?
23. Tolerating silence between you and the client has therapeutic benefits. How far do you agree?
Having no agenda
24. Having no fixed objectives when meeting clients, allows more free exchange with the client and creates more meaningful experiences. How far do you agree?
25. Rather than focusing on the client's problems, practitioners should listen for meaningful expressions and strive to help the client make sense of what they are feeling. How far do you agree?
Peer support worker
26. Peer support should be offered as part of all mental health care services. How far do you agree?
27. In mental health teams, peers (persons with lived experience) are of equal status and value of opinion. How far do you agree?
28. Peers (persons with lived experience) should be involved at every level of service delivery. How far do you agree?
29. Peers (persons with lived experience) provide a different experiential level of understanding of a client's distress, that is important to include in mental health care. How far do you agree?
Having no 'expert' role
30. The primary role of a practitioner is to create a safe space where the client and their network feel free to speak. How far do you agree?
31. Practitioners are there to support the mutual learning between themselves and the client, both sides learn from each other. How far do you agree?
32. Saying less as a practitioner rather than more is an effective way of treatment care. How far do you agree?
Family importance
33. Including and supporting a client's social network as soon as possible, is an important part of mental health care. How far do you agree?
'Nothing about them, without them'
34. Practitioners should never talk about a client without the client being present. How far do you agree?
35. All issues and solutions should be openly discussed with the client for effective therapeutic treatment. How far do you agree?

(Continued)

TABLE 4 (Continued)

Peer-supported open dialogue attitude and competence inventory (PODACI)
Attitude dimensions
36. Practitioners should not decide on any plans before meeting the client. How far do you agree?
Personal development
37. It would benefit me to understand my own life history in order to be of help to others. How far do you agree?
38. My personal values and attitudes have a major impact on how I communicate with my clients. How far do you agree?
Political and social influence
39. It is important to consider the political and social factors that may negatively impact a client. How far do you agree?
Attribute dimensions
Mindfulness
40. I pay attention to how my emotions affect my thoughts and behavior when talking with clients. How far do you agree?
41. When I have distressing thoughts or images during my meeting with a client, I make an effort to "step back" and be aware of the thoughts or images without getting taken over by them. How far do you agree?
42. Having a daily mindfulness practice can be an important part of my work. How far do you agree?
43. I endeavor to always be aware of the feelings that I experience when talking with the client. How far do you agree?
Self-compassion
44. Self-care is an important part of my professional work. How far do you agree?
45. When I feel down in some way, I try to remind myself these feelings are shared by most people in the service, and this may be a way that I can establish a connection with my clients. How far do you agree?
46. I feel comfortable expressing my sadness and worries in front of colleagues and clients. How far do you agree?
Emotional awareness
47. Responding to the client emotionally is often the most important work done in meetings. How far do you agree?
48. I give less primacy to the ideas of looking for a diagnosis or a solution, and instead, focus on the client and what is happening in their lives. How far do you agree?
Awareness of self-Bias
49. I can recognize my own biases that could negatively impact a client. How far do you agree?
50. Self-work is an important part of my development. How far do you agree?
51. Learning to know myself better is an important goal for my professional development. How far do you agree?
Self-disclosure
52. I feel confident in opening up and sharing my life experiences with clients and colleagues. How far do you agree?
53. I am able to discuss sensitive things about myself with the client if it is suitable and safe for both sides. How far do you agree?
Knowing when and what to self-disclose
54. I can disclose my own personal experiences to the client when I feel it would be beneficial for the client. How far do you agree?
55. It is sometimes better to stay quiet than to talk. How far do you agree?
Compassion
56. When a client is upset, I try to stay open to their feelings rather than avoid them. How far do you agree?
A humanistic approach
57. People often need a fellow human being to relate and talk to. How far do you agree?
58. I am able to care deeply about every client I work with. How far do you agree?
59. Just being a fellow human being is sometimes the most important thing a practitioner can offer a person in crisis. How far do you agree?
60. A practitioner is a human first, and then they are a human with some expertise. How far do you agree?
61. Being authentic and honest is an important skill that I try to practice on a daily basis. How far do you agree?
Giving away power
62. I am able to listen to my client, without stepping in and 'wanting to fix the problem'. How far do you agree?
63. I feel confident in letting the client lead the conversations and meetings. How far do you agree?
64. I am able to filter out ideas of diagnosis, solutions and stay attentive to the client. How far do you agree?
65. It is important that I understand how my position of power and privilege influences my relationships with clients. How far do you agree?
Accepting
66. I view clients for who they are and not based on their diagnosis. How far do you agree?
67. I take time to understand the client and their experiences. How far do you agree?
68. I am good at understanding an individual's perspectives. How far do you agree?

(Continued)

TABLE 4 (Continued)

Peer-supported open dialogue attitude and competence inventory (PODACI)
Attitude dimensions
Reflective of one-self
69. When I make mistakes in a meeting, I apologize to the client. How far do you agree?
70. There are always areas I can work to improve. How far do you agree?
71. I am open to feedback from my colleagues and clients. How far do you agree?
Tolerating uncertainty and silence
72. Tolerating silence between myself and the client is stressful (REVERSE). How far do you agree?
73. I can keep an open mind and allow space and time for a client to reflect. How far do you agree?
Relationships
74. I give a lot of attention to the family that surrounds my client and their relationship. How far do you agree?
Meeting priorities with clients
75. One of my primary goals is to facilitate an emotional exchange between the client and their network. How far do you agree?
Self-reflection
76. I am willing to watch myself back on video and reflect on areas that I may need to work on. How far do you agree?

When in use, trainees would be asked to give a rating based on a five-point Likert scale from 1 (Strongly disagree) to 5 (Strongly agree).

the PODACI. Such enthusiasm could reinforce the content validity of the PODACI (Goodman, 1987).

6. Conclusion

In conclusion, the current paper established an inventory that investigates the changes in POD trainees' attitudes and measures the general effectiveness of the current training course. The inventory consists of 27 domains and 76 items. A panel of POD practitioners and trainers reached a consensus on all the items that were included in this scale, while items with a low consensus throughout the Delphi rounds were removed. This study is a first step to fully develop and validate the PODACI. The next stage for the PODACI would be to test the inventory further on POD trainees, validating the instrument for its psychometric quality, and examining the reliability and validity of the items included. Further research also needs to assess the relationship between the attitudes and attribute items with OD principles and treatment outcomes, helping understand how certain types of items are related to a successful OD delivery. Additionally, pilot studies done on TAU and POD practitioners are required to see if POD practitioners score differently than TAU professionals (with POD practitioners expected to score higher) and if the inventory functions as intended. Once verified, researchers, POD trainers, and policymakers will have a working inventory to use.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. Written informed consent for participation was not required for this study in accordance with the national legislation and the institutional requirements.

Author contributions

VF responsible for the conceptualization and design of the manuscript, collected the data, performed the data analyses, and drafted the manuscript. JS drafted the initial version of the manuscript, reviewed, and revised the work. MH responsible for the conceptualization and design of the manuscript, reviewed, and commented the drafts. All authors contributed to the article and approved the submitted version.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1059103/full#supplementary-material

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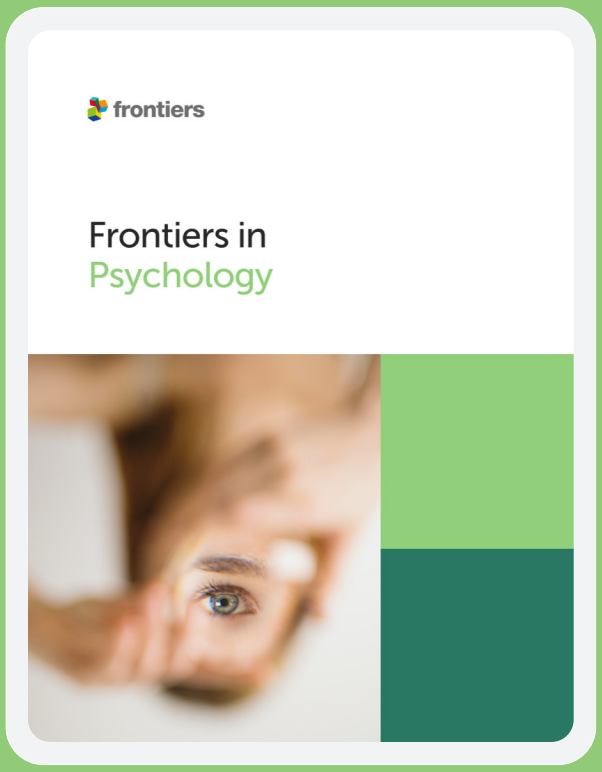

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