Open Dialogue trainees' expectations of 'shared concern'

An international focus group study

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Abstract

Open Dialogue is an alternative approach to service provision for people experiencing mental health problems. Training and implementation of dialogical ways of working require that professionals disposition themselves as experts and "unlearn" traditional therapeutic relations. This study explored trainees' discussions of their expectations of Open Dialogue as they commence their training. Four focus groups, two in Australia and two in Denmark, were analysed thematically. We generated the theme "shared concern" with four sub-themes: 1. "A democratising alternative", 2. "Waiting and listening", 3. "Acknowledging many kinds of expertise", and 4. "Personal participation". Rather than learning a therapeutic technique, "shared concern" in dialogical practices emphasised a collaborative approach to manage ubiquitous uncertainty and a political commitment to addressing inequities in service delivery. This variance from usual reasons to undertake training has implications for course design and delivery that have yet to be considered.

Key words: Thematic Analysis; Family Therapy Trainees; Focus groups; Open Dialogue; Qualitative Research, Uncertainty.

Practitioner Points:

- The theme "shared concern" was generated from across the focus groups, which was well-aligned with the doxa of Open Dialogue
- Trainees emphasised their experience of Open Dialogue as a moral counterapproach to traditional healthcare with less emphasis on the actual psychotherapeutic practices

Introduction

Open Dialogue is a resource-oriented approach for mental health (Priebe, Omer, Giacco, & Slade, 2014), which aims to mobilise psychosocial resources in a crisis-struck person's social network. This recovery-oriented approach includes a particular dialogical approach to psychotherapy and an emphasis on organising responsive and seamless healthcare pathways (Seikkula & Arnkil, 2006). It operates on the basis of core humanistic values of openness, social inclusion, and personal autonomy and genuine user and family participation in decision-making processes (Ong et al., 2019). Open Dialogue practices comprise, amongst others, efforts to include clients' social networks and flatten traditional hierarchies between consumers and clinicians as well as between clinicians.

Open Dialogue was developed gradually in Western Lapland in Finland from the early 1980s to the mid-1990s. It grew out of a therapeutic approach for treating and rehabilitating people diagnosed with schizophrenia, named "need-adapted treatment" (Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991). Need-adapted treatment emphasised a flexible and psychotherapeutic approach to the individual person and their family, including family-oriented therapy. Open Dialogue extended the need-adapted treatment by implementing mobile crisis intervention teams for people with psychosis and having a particular dialogical focus on the communication in a crisis-struck person's social support system. The development of Open Dialogue took place during a gradual, but substantial re-organisation of the psychiatric services, where individually tailored crisis teams comprising relevant outpatient staff, became responsible for treatment and for inviting other relevant agencies to join treatment meetings (Seikkula, Alakare, & Aaltonen, 2001). Open Dialogue approaches have since been adapted and implemented in several social and mental healthcare settings outside Finland. Implementations in Scandinavia have had varying levels of success and sustainability (Buus et al., 2017).

Open Dialogue training is often distinct from traditional didactic-style learning and is, instead, based on an unstructured and highly experiential approach to learning. This style of training has been reported to generate profound emotional experiences (Dawson, River, McCloughen, & Buus, 2019; Pope, Cubellis, & Hopper, 2016; Stockmann et al., 2017). Pope et al. (2016) reported findings from anthropological fieldwork during the implementation of

Open Dialogue training in the Parachute NYC project (Parachute NYC, 2015). They found that the "need-adapted" training lacked the instructional clarity of more manualised training programs, and some participants found the training disorganised. Pope et al. suggested that participants' struggles to grasp the need-adapted model was not only linked to obscure training materials, but also to the processes of apprenticeship learning (Pope et al., 2016).

Putman (2015) states that Open Dialogue trainees develop their psychotherapeutic skills through extensive supervision, immersion in a variety of literature, exploration of different aspects of their work, and engagement with their own personal networks; all in the service of a more open, free and responsive way of being with others. Further, Putman (2015) refers to Open Dialogue training as having an aspect of "unlearning" that can take many forms. This is because "prior" learning - through both personal development and conventional professional learning - can be highly limiting in Open Dialogue contexts. Schubert et al. (2020) explored the professional identity of Australian clinical psychologists and psychiatrists after they recently participated in introductory Open Dialogue training and had trialled clinical implementation of the approach. The findings indicated that the training facilitated opportunities for taking alternative positions in their clinical work that to a larger extent involved their personal selves. This was sometimes perceived as exposing and putting the clinician in a vulnerable position.

Open Dialogue is often positioned as a challenging, "counterhegemonic" (Hopper, Van Tiem, Cubellis, & Pope, 2020), alternative to conventional mental health approaches with complex therapeutic practices that are difficult to learn and implement in sustainable ways (Buus et al., 2021; Waters et al., 2021). To our knowledge, there is no published research on trainees' expectations of Open Dialogue training, and we were interested in studying the early professional socialisation processes in the approach.

Aim

The present study aimed to explore Open Dialogue trainees' expectations of the psychotherapeutic approach at the beginning of their training courses in Australia and in Denmark.

Methods

We designed a focus group study of trainees participating in four different Open Dialogue training courses with varying duration and levels of assumed prior knowledge and experience. The focus group design was relevant to this study because focus groups can give insight into group meanings, processes and norms linked to a researcher-defined topic (Bloor, Frankland, Thomas, & Robson, 2001). Focus groups make use of psychosocial group dynamics to produce data and insights that would not be available using alternative methods (Morgan, 1997).

Focus groups and participants

The two countries were at different stages of Open Dialogue implementation. In Denmark there are well-established sites with decades of experience of training practitioners in Open Dialogue as well as implementing Open Dialogue clinical practices. Australia does not yet have such sites. The Open Dialogue training programs are described in table 1.

Participants in focus group #1 and #2 were recruited in Australia at a three-year Open Dialogue psychotherapy course and a two-year Open Dialogue trainers' course. As the name indicates, the trainers' course was designed for experienced family therapists to become Open Dialogue trainers. The two Australian courses included a total of 61 and 40 days, respectively, of face-to-face teaching including supervision and family-of-origin work, with additional literature studies undertaken individually and in groups outside of the study days. Participants in focus group #3 and #4 were recruited in Denmark. Participants in focus group #3 were recruited from a two-year Open Dialogue psychotherapy course that included 18 days of face-to-face teaching, individual literature study and 90 hours of literature studies groups and supervision. Participants in focus group #4 were recruited from a one-year Open Dialogue psychotherapy course that included 10 days of face-to-face teaching, individual literature study, and 50 hours of literature studies groups and supervision. Participants from all four groups were a mix of professional groups with the vast majority being health care trained. Participants in the Danish focus groups all had bachelor's degree qualifications, whereas participants in the Australian focus groups had a mix of bachelor's, master's, and doctoral degree qualifications.

[Insert table 1 approximately here]

All participants on the four courses were sent an email with a brief description of the study and a request for permission to send a Participants Information Sheet, which contained more detailed information on the study procedures and participation requirements. If permission was granted, a member of the research team offered additional verbal information, and answered any inquiries, and sought written consent to participate in the research.

Data generation

All focus groups were organised following the same procedure led by one (ML, Denmark) or two (AM and NB, Australia) moderators. ML was the leading organiser of the Danish courses, and AM and NB were participants in one of the Australian courses. First, moderators provided a brief introduction to the study's aim and to the organisation of the focus group: practical arrangements and timeframe; and an agreed upon respect for different opinions and confidentiality. Second, moderators introduced the agenda, which was organised around six statements (see table 2) printed on laminated A5-sized cards and laid out in front of the participants. The statements were generated by the authors on the basis of our clinical experiences, our experiences as trainers, and on the current research literature. The statements were designed to generate rich descriptions of the participants' understanding and expectations of the Open Dialogue approach contextualised to their various work situations,. In this way, participants' anticipations and assumptions (expectations) could be expressed in tangible ways. As part of generating group cohesion, focusing attention and orientation to the topic, the participants were asked to collectively decide on the order in which they wanted to discuss the statements. Sessions ended with a short debriefing and evaluation of the focus group. Moderator involvement was planned to be minimal throughout the focus groups as we were interested in how the participants negotiated the statements.

[Insert table 2 approximately here]

The focus groups were audio-recorded and transcribed verbatim by MFP with indications of basic turn-taking features, including interruptions and overlapping speech (ten Have, 2007). The quality of the transcriptions was assessed and marginally improved through a subsequent comparison to the audio-recordings by NB. Translations of Danish data extracts into English were made by NB who prioritised the cultural equivalence between original statements and translations rather than direct word-to-word translation.

Data analysis

The analysis was a constructivist reflexive thematic analysis (Braun & Clarke, 2006, 2019) that included an analysis of how topics were negotiated in the discussions (Morgan, 1997). The analysis was iterative and organised in line with Braun and Clarke (2006, 2020) six-stepped approach with extensive memo writing as the key driver of analysis and interpretation across stages. Step one was a 'familiarising' with the data, which included reviewing the audio-recordings and writing down and discussing first impressions (AM, NB and MFP). Step two was an open, 'initial coding' by NB of the thematic content of the transcripts and an analysis of conversational turn-taking structures. This, for example, included the identification of thematic content and how the following speakers responded to it. These responses would most typically include a polite acknowledgement of a statement followed by a modest upgrading or downgrading of the statement. This, in step three 'searching for themes', led to NB constructing 28 potential themes. This, expectedly, had some resemblance to the topics from the interview agenda. Driven by our memo writing, step four 'reviewing themes', refined the analyses and enabled us to collate and reduce the number of potential themes. In step five, 'naming themes', and step six, 'reporting', we defined a central theme and four sub-themes by interpreting significant quotes and validated them by re-examining the original audio recordings and the transcripts to determine whether the identified theme and the data extracts represented a nuanced and balanced interpretation across the four focus groups.

Ethics

The University of Sydney Human Research Ethics Committee approved the research of Australian focus groups (reference #2017/5883). We notified the relevant Danish regional research ethics committee and the Danish Data Protection Agency about the Danish focus groups; neither institution reported any reservations toward the study. All participants gave their informed consent to participate based on written and oral information about the study. Responses were managed in full confidentiality, and all details that could potentially be used to identify individual participants have been altered in the data extracts presented in the following results section.

Results

Our analysis of the participants' discussions of their expectations of Open Dialogue in the context of their early Open Dialogue training, led us to generate a theme, "shared concern", and four sub-themes: 1. "A democratising alternative", 2. "Waiting and listening", 3. "Acknowledging many kinds of expertise", and 4. "Personal participation".

"Shared concern" implied a continual worry held by participants about clinical actions and decision-making as well as a personal commitment to genuinely support clients and their networks. Participants perceived Open Dialogue as a response to discomfort with and resistance to existing conventional practices that were experienced as paternalistic and prescriptive, while also acknowledging these structures had a role in reducing anxiety about particular clinical uncertainties. In the context of these tensions, participants expected that Open Dialogue clinicians would always only have incomplete insight into clients and their networks and would therefore feel obliged to collaboratively explore situational complexities and unknowns, rather than routinely resort to quick and standardised decision-making, pathologising, explaining or diagnosing. Participants held concerns about how holding fixed views may stymie the generation of novel and creative solutions to complex problems, whilst also recognising that in some circumstances the continued act of listening without asserting alternatives could have the quality of perpetuating a sense of stagnation. Participants expected that Open Dialogue clinicians would appropriately share their professional and personal concerns with clients and colleagues. Shared practices and values were expected to support development of a particular professional identity and community, which would foster relations that were described as central to creating more equitable and transparent mental health services.

The focus groups differed somewhat in the way they spoke about Open Dialogue. The Danish participants, who were more experienced with Open Dialogue, described its concrete practices, demarcating and legitimising the approach though an emphasis on alignment with their existing, recovery-oriented treatment philosophies. The Australian participants described Open Dialogue abstractly by its principles, which were conceptualised as a fundamental break away from previous practices and which contextualised participants' concerns related to uncertainty about the treatment philosophies and practices on the fringe of their mental health services.

1. A democratising alternative

The participants described Open Dialogue as an alternative to more conventional approaches to mental health care. This included depicting Open Dialogue as more collaborative and as capable of democratising clinical decision-making processes and flattening traditional hierarchies between clients and clinicians as well as between clinicians. Key to this were explicitly shared decision-making processes that allowed clinicians to share their considerations with clients and colleagues to a larger, and more nuanced extent than in conventional encounters. Furthermore, participants warned against the use of absolute language-use, which would violate a fundamental idea of acknowledging uncertainty and entrap clients linguistically. In doing so, participants tended to distance themselves from the practices in conventional mental health services as sites for paternalistic, medically dominated and non-democratic decision-making.

In the following data extract from focus group #2 (AUS), the participants were discussing their expectations of changes to interprofessional collaboration. In order to represent overlapping speech without significantly reducing readability, we have placed overlapping speech in [square parenthesis].

Christian: I think about it (Open Dialogue) providing a structure for communication from different models or perspectives. That one model is not right or more correct in this circumstance. Something like "let's try to understand what it is that you're bringing to this, and how you are approaching this, and what it is I am bringing to this, and how I am approaching it". I think dialogue just in and of itself gives you that structure to start having that conversation as well as that process of flattening the playing field [Frank: The change of hierarchy]. You know, it moves it out of "the psychiatrist is the person who makes the decision about which one of these models has been presented in a multidisciplinary team is the one we are going to follow", you know, "CBT sounds good for this one or we will do that." "Family therapy is needed here; we will do that". It's sort of [Gaby: Sharing responsibility, isn't it?] Yeah, there isn't just one person that got some sort of special expertise that has to be regarded as more important or better than others.

Gaby: But it just struck me, that for those who are collaborating, there is a sharing of risk and a sharing of burden and responsibility. Which sounds attractive. It's a benefit.

Christian: I don't know. I think sometimes there is a comfort in being able to hand it to [Brenda: there is a comfort in?]. To being able to say [Brenda: to make a decision?] "I have told the medical director about this, so it is not my responsibility anymore if something bad happens" [Brenda: Okay]. I think that for some people not taking a shared part of the risk, actually [Brenda: It is difficult] is a tricky thing.

Christian describes Open Dialogue as a "structure for communication" that allows for explorations of what each participant is communicating. He resists Gaby's suggestion about the attraction of "sharing responsibility" and presents a counter-example that it can be relieving for some clinicians to say that the medical director has been informed and thus placing formal responsibility with the director. Through the data extract, the participants collaboratively emphasised "dialogue" as a "structure" that in itself can open up "conversation" by not assuming any perspective being more correct than any other and can flatten interdisciplinary hierarchies where psychiatrists have usually taken a privileged position.

2. Waiting and listening

Participants described Open Dialogue as different from conventional approaches because Open Dialogue clinicians would take more time to listen and acknowledge conversational

partners and prioritise – if possible – a period of patiently waiting before making significant decisions about any intervening. “Slow” decision-making processes were described as a more appropriate way of working because the clinicians would not have all the answers to the clients’ questions and problems. They expected this would create awareness and the opportunity to articulate this concern in their work with clients and colleagues. “Slow” decision-making was described as, ultimately, more effective than more standardised decision-making that was described as too often being wrong after a period of time.

In the following data extract from focus group #4 (DK) participants were discussing situations where clients were reluctant to take responsibility for their own situation, which was regarded as an important goal in a recovery-oriented context. It is relevant to note that in the Danish context “containing” is a metaphor for the psychosocial “holding” of someone’s distress.

> Louise: Yes, but it can be hard work sitting with someone who is in a very tough situation [Eddie: Yes] and be able to contain. That thing about not taking responsibility (from the person). I remember from when we were taught about compassion fatigue, that it is not hard to be empathic, if you’re moving forward. But the thing about containing and containing and containing, but not (moving forward). But if you have the OD approach, where containing is the point, then I do something simply by containing, yeah.
> Karen: That makes a lot of sense.
> Fiona: That is correct, you do something [Louise: Exactly, exactly] simply through listening. That is also doing. So, if it can settle your urge to fix things, then you are fixing, while you are listening [Louise: Exactly] and that is also doing.
> Karen: Maybe it becomes more all right, more ok? What is the word? The opposite to prohibited [Louise: Acceptable] [Eddie: Legal].

Louise introduces empathy and links it to “containing”, which is repeated three times, to emphasise the fatigue and strain on the clinician who is experiencing an impasse and metaphorically filled with the client’s distress. The participants collaboratively emphasised some of their challenges by using words like “hard work”, “compassion fatigue” and not “moving forward” in a context of not wanting to take “responsibility” away from the person despite having an “urge to fix things” for them. Their reference to containing in an Open

Dialogue approach legitimised seemingly passive activities, such as “listening” and “containing”, by recognising the “doing” in them.

3. Acknowledging many kinds of expertise

Participants also thematized “shared concern” by highlighting the potential fallibility and limitations of their own professional expertise. Conventional clinical expertise was depicted as privileged and, therefore, problematic. Working in line with Open Dialogue was depicted as including a radical decentring of clinical expertise to be pari passu with other types of expertise. Furthermore, expertise in Open Dialogue was depicted as asking clinicians to engage with their personal self as much as their professional role, and to put themselves “at stake”, making themselves vulnerable in interactions with clients and colleagues. Descriptions of accepting several, equal kinds of expertise created, on one hand, an image of a reduced conventional expertise, and, on the other hand, a legitimising acknowledgement of a clinical-personal expertise.

In the following data extract from focus group #1 (AUS), the participants are discussing their expectations of what it means to work dialogically.

> Linda: I think understanding power is an important part of it as well. I wonder, if you to be dialogical have to understand what is like to be not dialogical or the history around non-dialogical practice. It is to understand how this interaction, even if you are coming at it from a human perspective, is not just you and this other person as two humans. There’s 150 years of psychiatry behind that in setting that structure up, and I don’t know if you could be dialogical without understanding what else is in the room, and how you work around that to create dialogue.
>
> Kate: In regard to expert, who is the expert? I often think: “How dare I have the audacity to assume that I could be the expert on the person sitting before me”. They are the experts in their lives.

In the data extract, dialogical practice is contrasted with non-dialogical practice, which is described as a foundational part of conventional mental health care. This can be seen as a dialogical stance, as it in effect is an invitation to consider how psychiatric power is already part of any interaction, including dialogical interactions. This organisational understanding of the “non-dialogical” is supplemented by a stance towards the fallacy of ever assuming to be

the expert on another person's situation. Participants in all focus groups emphasised that Open Dialogue would not be appropriate with all clients, as there might be clients who expect to be presented with a tenor of certainty about being "fixed" and receive individually-focused treatment.

4. Personal participation

The ways in which Open Dialogue engages the clinicians' personal self was also highlighted as a point of difference compared to other approaches. Reflections in front of families were described as events where both professional and personal thoughts were shared by clinicians. Moreover, the participants described several approaches to learning Open Dialogue that drew heavily on notions of experiential learning. According to the participants, Open Dialogue was described as impossible to comprehend through being taught deductively, as it could only be fully appreciated through participation. Learning Open Dialogue necessitated personal participation and critically questioning one's own previous practices. Finally, the participation in reflective practices was described as personally fulfilling. A personal expertise was highlighted by some participants who spoke about Open Dialogue specialists as "embodying" a dialogical stance and described it as a way of life, more than competently mastering a psychotherapeutic approach.

In the following data extract from focus group #3 (DK), the participants had just started discussing how Open Dialogue is learned.

> Lisa: I think there is a massive difference between hearing about it and trying it. I remember the first time I did a reflection and came out from that meeting and thought "Shit, the sensation in my body is wild [Ben: Yes]. And it sounds a little hippie-like, and I am hardly a hippie, but it was just. I remember saying to Tom who led the meeting, "Wow, that was just wild". So, for me, something happened. It sounds weird, religious, right? It is because it was so different.
> Louisa: I can somewhat recognise what you are saying. I have been at the Forrest Lodge (institution) for two years and was introduced to it (Open Dialogue) there and got enthused. I still am, because I think it can be used to achieve a lot. I have also had the experiences of being completely, really touched, about how much it can open up. At the same time, I think that it is not hocus-pocus, not hippie-like, not at all. I think that we are very far from speaking properly with each other, that this is the way to

> speak. Openly and honestly. Let's give each other some space. In that way, I don't think there is any hocus-pocus about it.

In this data extract, a "wild", conversion-like personal experience of trying reflection in Open Dialogue the first time was self-evaluated as sounding "hippie-like" and "religious" despite the speaker explicitly not identifying as a "hippie". The second speaker slightly downgraded the description of Open Dialogue from "wild" to "enthused", and she further elaborated on the point that Open Dialogue was not "hocus-pocus", but the proper, "open and honest" way of talking. In this way, Open Dialogue was positioned and legitimised, very similar to data extract 2, as a powerful, natural way of communicating, rather than an indeterminate magical practice.

Discussion

Our analysis generated a prominent theme "shared concern" and four sub-themes that accounted for different ways of describing trainees' expectations of an alternative, personally engaging approach to mental health care with a strong moral ethos. The actual clinical practices of Open Dialogue were only vaguely described, and the approach was described more as a morally just, counter-narrative to traditional approaches than a psychotherapeutic model.

"Shared concern" is well-aligned with the doxa of Open Dialogue, seen, for instance, in key textbooks (Seikkula & Arnkil, 2006, 2014). These texts frequently refer to the Russian literary scholar Bakhtin's notions of the fundamental "unfinalizability" of human subjects and, in particular, how the Russian author Dostoyevsky invented the idea of the polyphonic novel, which is based on interactions between autonomous, unfinalized consciousnesses, represented by inner and outer voices (Bakhtin, 1984). However, in the focus groups "shared concern" reflects many types of uncertainties and ultimately subsumed a relativist understanding of knowledge and expertise where "nothing is certain", as well as an acknowledgement of clinical and existential uncertainty and personal vulnerability. Our sense is that there would be an important difference between the Bakhtinian formulation of "uncertainty", which urges caution about what is known, because knowledge is incomplete, and the uncertainty of "shared concern" that nothing can be known with certainty. The engagement with this latter relativist notion of uncertainty may be a reaction to the more

paternalistic contexts in which many study participants worked. Both meanings may inform the therapeutic endeavour but may emphasise different aspects of the therapy (and therefore of training) – the former, perhaps prioritising tentativeness and the latter cautioning against dogma.

Descriptions of Open Dialogue are typically deliberately kept indeterminate to pay homage to its need-adapted character, and we do not assume that there is a single, authoritative reading of an Open Dialogue approach. We suggest that the participants' expectations in "shared concern" interpellated particular aspects of Open Dialogue and ignored others. It is possible that certain readings of Open Dialogue attract certain people with particular interests in critiquing and changing conventional mental health care provision rather than in the details of dialogical psychotherapies.

Open Dialogue has taken hold of the imagination of parts of the recovery and human rights and disability movements (Lakeman, 2014; von Peter et al., 2019). In a study of the Parachute NYC project, Hopper et al. (2020) described this intervention as "counterhegemonic", and stated that the peer workers had a more lasting enthusiasm for the approach. As Parachute NYC combined Open Dialogue with Intentional Peer-Support, it is possible that Open Dialogue was interpreted with an anti-dogmatic emphasis on being a non-directive and anti-medication approach. This interpretation is in contrast to the conclusions of Galbusera and Kyselo's (2018) conceptual analysis of the Open Dialogue approach, which suggested "openness" and "authenticity" as necessary and constitutive aspects of the Open Dialogue therapists' attitude to the client. Galbusera and Kyselo's analysis emphasises the approach as a psychotherapeutic model with less emphasis on offering a counter-position as in Parachute and on unfinalizability as in the current study. While these studies are not directly comparable, we believe that they hint at very different readings of Open Dialogue approaches. We are concerned that unnuanced readings of Open Dialogue can lead to unfruitful othering of the conventional services and add to unrealistically hopeful expectations of the therapeutic or collaborative merits of Open Dialogue.

In the process of learning to practice Open Dialogue, trainees in the current study can be understood as gradually becoming members of Open Dialogue "communities of practice" (Wenger, 1998). From this social learning perspective (Lave & Wenger, 1991), collaborative construction and sharing of "shared concern" were sources of knowledge and legitimisation

of community membership. While there are not many studies that describe family therapist students' expectations or experiences of training, a few studies have examined the interactional development of professional identities. One exception is Nel's (2006) Interpretive Phenomenological Analysis (IPA) of interviews with six family therapy trainees over approximately 20 months. The trainees often found the training "overwhelming" and "uncertain", and felt "de-skilled" and in need of "re-skilling" which, provoked re-evaluations of their established personal and professional identities.

Another exception is Fragkiadaki et al.'s (2013) IPA exploring the identities of students of systemic psychotherapies, which found that participants experienced professional development in an accepting community that offered support at a personal and a professional level. Among the Open Dialogue trainees in our study, there was a shared emphasis on joint personal support, but whereas a key reason for joining the systemic psychotherapy community for the psychotherapist students in the studies by Nel (2006) and Fragkiadaki et al. (2013) was to learn clinical skills, the Open Dialogue trainees of the current study were committed to changing inequitable knowledge asymmetries in healthcare service delivery. So, while the concerns identified by Nel (2006) and Fragkiadaki et al. (2013) may also have been present amongst the Open Dialogue trainees, the reasons for embarking on Open Dialogue training also considered prominent broader contextual challenges that were seen to be problematic and entrenched. These different orientations are perhaps related to different disciplinary trainings, workplace tasks and expectations, and cultural assumptions about therapy that are shaped by experience of the demands as well as the culture of an organisation. It is not clear if they represent sites of conflict or disappointment as the Open Dialogue clinicians gain experience and legitimacy as therapists and learning may be focused on their counselling skills rather than their moral stance.

Limitations

We invited all trainees in the four training programs to participate in the focus groups, but not all chose to participate. We did not systematically explore reasons for non-participation, and we are aware that the recruitment process could potentially promote some voices (including those that advocate for broader systems change) and limit the contribution of others. Furthermore, the focus group participants were at the beginning of their Open Dialogue training programmes and a study of more seasoned Open Dialogue practitioners could

potentially reveal significantly different uses of “shared concern” and descriptions of their practices.

The position of the authors of the paper was influenced by our personal engagement with Open Dialogue practice, education, and training, and our already-established relationships with some of the study participants. We believe that our adoption of the dialogical idea of ‘polyphonic’ conversations in the focus groups strengthened participants’ sense of safety and trust and, with that, also the quality of data. While acknowledging that we as a group of interpreters could offer stereotypical interpretations, we believe that our collaborative research process continually challenged individual interpreters’ preconceptions. In order to transparently demonstrate how our positioning influenced our interpretations, we presented lengthy, contextualised data extracts and our readings of them. We recognise that the context of the training environment might also impact the views of the trainees, and while this paper offers insights from four separate locations, the generalizability of findings remains limited. Finally, we examined and edited the draft paper using the reflexive questions suggested by Braun and Clarke (2020), and we believe that there is as good fit between the research aims, the demonstrated conceptual positions, and the methodological procedures.

Conclusion

“Shared concern” was highly valued in contrast to the ‘certainty’ of traditional health care approaches and training methods in mental healthcare. Open Dialogue as a practice is relatively novel in some health care contexts but has generated sufficient interest for practitioners to seek or continue to seek further training in Open Dialogue. This study identifies important reasons why a clinician may invest time, energy and other resources in undertaking further training. While some of these reasons relate to expectations of the development of certain practices (such as the skills of waiting and listening, of facilitating dialogue, and supporting decision making in therapy) and the development of the self of the therapist, a number of responses seem to position the commitment to training as a means of addressing broader ethical and organisational dilemmas that therapists encounter in their professional contexts.

The participants in the current study emphasised their experience of Open Dialogue as a moral counterapproach to traditional healthcare with less emphasis on the actual

psychotherapeutic practices. Similar to other studies there was an emphasis on the hope that dialogical practices might hold, however, there are potential risks in avertedly othering and reifying Open Dialogue too much. Understanding that such expectations may be present in trainees in a modality that ostensibly occurs in the therapy room or the home is important for developers of training programs to consider, perhaps in order to ensure that the training addresses these concerns or otherwise to manage these often lofty expectations. A topic for future research is whether Open Dialogue attracts professionals that are searching for hopeful alternatives to more traditional mental health practices and how much the approach itself (or its training methods) invites and encourages such responses.

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Table 1. Focus groups

	Date	Size	Location	Length (minutes), not including breaks	Training	Participants	Work context
#1	November 2017	n=6	Australia	115	Mix of 2 and 3-year course	Multidisciplinary	Mental health
#2	November 2017	n=5	Australia	108	Mix of 2 and 3-year course	Multidisciplinary	Hospital-based mental health staff
#3	January 2018	n=6	Denmark	74	2-year course	Multidisciplinary	Community mental health
#4	September 2019	n=6	Denmark	69	1-year course	Multidisciplinary	Community mental health

Table 2. Agenda statements

- What do you need to be good at to be extraordinarily good in your current professional role?
- How do you learn the Open Dialogue approach?
- Barriers for the Open Dialogue approach: Personal and organizational?
- Benefits of the Open Dialogue approach: Personal and organizational?
- How might the Open Dialogue approach change inter-professional collaboration?
- What does it mean to work dialogically?