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ORIGINAL ARTICLE

Open dialogue trainees' perspectives on learning processes and psychotherapeutic practice: A prospective focus group study

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Abstract

Open Dialogue is a collaborative approach to mental health care emphasizing integrated services and a dialogical psychotherapy approach. Open Dialogue training programs eschew traditional didactic teaching of technical therapeutic skills in favor of more experiential learning processes. It is unclear how these training programs affect trainees and shape their perspectives on Open Dialogue. Our aim was to follow up a group of Australian Open Dialogue trainees and explore their perspectives on learning processes and psychotherapeutic practice. We utilized a prospective focus group design with data from audio-recorded focus groups convened before (n = 2) and after (n = 3) participants completing an advanced Open Dialogue training program. Data were subjected to reflective thematic analysis. We identified the theme "Extending possibilities by holding ideas lightly," which represented a universal principle that participants applied to multiple aspects of their practice, for example, favoring multiple perspectives and approaches to therapy, including those other than Open Dialogue. This theme had two sub-themes: (1) "Allowing intimacy by being aware of personal biographies" and (2) "Learning by joining others," which reflected an increased willingness by participants to reflect on and share their inner experiences and an emphasis on joint experiential exercises in the training program. "Extending possibilities by holding ideas lightly" facilitated a means of incorporating a dialogical perspective into existing practices thus avoiding the potential barriers to a wholesale implementation of Open Dialogue. Findings indicated that the participants were not learning how to practice a therapeutic tech-

nique or propositional knowledge, but were socialized into a dialogical way of being.

KEYWORDS
focus group, open dialogue, thematic analysis, training

INTRODUCTION

Open Dialogue is a collaborative approach to mental health care that emphasizes seamlessly integrated services and a particular dialogical approach to psychotherapy applied to network meetings with people experiencing psychosocial distress and members of their social networks (Seikkula & Arnkil, 2006). It has been adopted to fit the local condition of healthcare services and implemented in numerous services across the globe (Buus et al., 2017; Buus, Ong, et al., 2021; Lennon et al., 2022). The approach was heavily inspired by systemic family therapies during its gradual development in Finland in the 1980s and 1990s (Haarakangas et al., 2007). It is often explained by referring to seven needs-adapted principles first published in the early 2000s (Waters et al., 2021): (1) Immediate help, (2) A social network perspective, (3) Flexibility and mobility, (4) Responsibility (of the professionals), (5) Psychological continuity, (6) Tolerance of uncertainty, and (7) Dialogism. These principles offer guidance on organizational aspects of care and treatment as well as the therapeutic stance of practitioners.

The importance of the principle of dialogism is not unique to Open Dialogue and is shared by the separate, but convergent collaborative family systems approach developed in the USA by Anderson and Goolishian (1988). Both approaches place importance on the promotion of a transformative dialogue characterized by an openness or receptivity to understanding the other and a willingness to share or go public with aspects of one's self (Anderson, 2001; Cooper et al., 2013; Galbusera & Kyselo, 2018). Open Dialogue and dialogical approaches are therefore heavily tilted towards promoting equality and collaboration between therapists and clients and stand in stark contrast to more directive forms of family therapy that promote therapists' expertise, such as strategic and structural approaches (Flaskas, 2010). Dialogical approaches have been informed by a number of philosophical influences (e.g., Bakhtin, 1981, 1984; Buber, 1996; Shotter, 2006, 2011), which has resulted in a broad and potentially confusing range of recommendations for the practice and training of practitioners that focus more on the dialogical stance and mindset of the clinician rather than on technical skills (Ong & Buus, 2021). This focus has made Open Dialogue less amenable to the development of manualized programs for both training and practice.

Over time, Finnish Open Dialogue clinicians and researchers have developed concomitant curricula for teaching Open Dialogue consistent with the philosophical assumptions of the approach, which embrace a dialogical "withness-thinking" (Shotter, 2011). This includes an experiential approach to learning and an emphasis on the Open Dialogue trainees' personal development rather than didactic teaching of technical skills. Therefore, the focus of learning in Open Dialogue is the development of "a more open, free and responsive way of being with others" (Putman, 2015, p. 34). Unlike some family therapy approaches where there are widely-accepted manualized training curricula, there is no standardized or manualized training for Open Dialogue. A number of training courses have been developed around the world, ranging from brief introductory courses delivered in days to a week, through to comprehensive 3-year part-time courses with extensive small-group supervision and Family of Origin work. There has been a small number of attempts to investigate and validate these varied training courses.

Administering a before and after survey, Jacobsen et al. (2021) evaluated a Norwegian 6-day Open Dialogue training course aimed at developing participants' capability to lead an Open Dialogue

network meeting. The training course was delivered over a 6-month period and included classroom teaching, supervised exercises, and small and big group discussions. Out of 42 course participants, 37 (88%) completed the first in-house training evaluation questionnaire and 28 (67%) completed the second. The results indicated that participants' learning outcomes and confidence with using Open Dialogue with patients, social networks, and professionals increased significantly throughout the training program. However, these findings should be interpreted with caution as the respondents of the second survey were significantly younger and more highly educated when compared with respondents of the first survey (Jacobsen et al., 2021). Stockmann et al. (2019) used a focus group approach to evaluate a one-year peer-supported Open Dialogue training course (part-time, four-weekly modular residential course) in the UK. An opportunistic sample of 26 trainees (48%) out of a total group of 54 trainees was recruited. Participants experienced the course as an emotional journey on which they engaged with the principles of peer-supported Open Dialogue both personally and occupationally. Training was seen as adding to a sense of "community," because learning was perceived as "shared," for instance through sharing personal experiences. However, some participants found the non-directive teaching to be anxiety-provoking and would have preferred more direct instruction (Stockmann et al., 2019).

To our knowledge, only one previously published project has explored trainees' experiences of undergoing extended Open Dialogue training. Wates (2019) and Wates et al. (2022) Interpretive Phenomenological Analysis explored the experiences and subjective impact on trainees undertaking a 3-year Open Dialogue training course in the UK. A sample of 13 trainees (46%) was recruited from a cohort of 28 trainee mental health practitioners. Data were collected during three focus groups, and the analysis identified four themes that were discussed from a Transformational Learning perspective: (1) A powerful experiential process; (2) Personal therapeutic change; (3) Experiencing deeper and more open relationships; and (4) Changing relationships with power in working practice. Following Seikkula's (2011) description of Open Dialogue as "a way of life" with therapists taking a non-interventionist stance and the challenges of integrating Open Dialogue into practice, Wates (2019) suggested that trainees "may need to undergo a transformational learning process, rather than simply adapting current practices." (p. 55); this transformational potential was confirmed in the study.

While there are no manualized curricula for Open Dialogue training, there is a shared orientation towards and a strong emphasis on experiential learning and trainees are positioned "in" dialogues as they learn about dialogues. Such a flexible teaching format challenges conventional understandings of teaching curriculum and psychotherapeutic skills acquisition. Open Dialogue training has departed from traditional didactic approaches focusing on developing technical skills to one that is more consistent with the values of collaboration, openness, responsiveness, and equality. This has resulted in training approaches emphasizing personal changes through shared experiences, reflection, and development of community. This study aims to further explore these learning experiences by prospectively following and exploring the experiences of trainees as they initiate and complete extensive Open Dialogue training in Australia. We also aim to promote discussion and to consider the implications, application, and effects of this teaching approach on family therapy training more generally.

MATERIALS AND METHODS

The prospective study design included focus groups conducted before and after participants' completion of extended (2 or 3 years) Open Dialogue training. A focus group design was relevant to this study as focus groups collect multiple types of data at once and can give insight into group meanings, processes, and norms linked to a researcher-defined topic (Bloor et al., 2001). Focus groups make use of interactive processes, in addition to individual-level feedback and group consensus (or lack of) regarding a phenomena of interest to generate data and insights that would not be available using alternative methods (Morgan, 1997; Pyr, 2016).

Study context: The open dialogue courses

Participants were recruited at two overlapping Open Dialogue courses commencing in Sydney, Australia in late 2017: a 3-year Open Dialogue psychotherapy course for participants with minimum of a bachelor's degree in healthcare, social care, or education, and a 2-year Open Dialogue trainers' course for experienced family therapists to become Open Dialogue trainers. Large parts of the curricula overlapped between the two courses and a significant part of the training took place in a single large group combining all participants from both courses; however, in small group work the course participants were separated into their own course streams. The courses included a total of 61 and 40 days, respectively, of face-to-face training, including supervision and Family of Origin work, with additional literature studies undertaken individually and in groups outside of the study days. Moreover, the participants needed to document 300 and 250 h of therapeutic work, respectively, and write a thesis to graduate.

The curriculum literature prescribed to trainees emphasized dialogical, reflective, and collaborative practices in working with clients, families, social networks, and couples. Supervision and Family of Origin work took place in small groups and drew extensively on reflecting teams (Andersen, 1987, 2007). In supervision sessions, trainees presented video recordings of their clinical work using Open Dialogue. Family of Origin work focused on trainees' relational identity through completing genograms and actively exploring significant relationships in the trainees' family and social networks, which could activate strong emotional responses among the participants. This work provided trainees with reflections on their clinical and personal identify as well as providing them with the experience of being a subject of others' reflection similar to what families may experience in an Open Dialogue meeting.

Participants

Invitations to participate in the pre-training and the post-training focus groups were distributed by the course leaders, and interested trainees subsequently contacted the research team for further spoken and written information about the study and then made an informed decision about becoming a participant. Participants and focus group composition varied due to the different duration and completion times of the two training groups. Participants belonged to different health care and social care disciplines and all worked in mental health (see Table 1). Their ages ranged from 33 to 70 years, and they had been qualified between 2.5 and 40 years.

Data generation

There were two pre-training focus groups conducted at the initiation of training (#1 and #2) comprising of a mixture of participants from the two training courses, and three post-training focus groups at the completion of training comprising of participants from the 2-year course (#3 and #4), and participants

TABLE 1 Focus groups

	Date	Size	Length (minutes), not including breaks	Training course	Mode
#1	November 2017	$n = 6$	115	Mix of 2 and 3-year course	Face-to-face
#2	November 2017	$n = 5$	108	Mix of 2 and 3-year course	Face-to-face
#3	September 2019	$n = 5$	96	2-year course	Face-to-face
#4	October 2019	$n = 5$	101	2-year course	Face-to-face with two participants online
#5	November 2020	$n = 3$	98	3-year course	Fully online

from the three-year course (#5). Approximately half of the participants participated in both a pre-and post-training focus group. All focus groups were organized following the same procedure and led by one or two (NB and AM) moderators. NB and AM were participants in the three-year course. First, moderators provided a brief introduction to the study's aim and to the organization of the focus group: practical arrangements and timeframes as well as confidentiality. Second, moderators introduced the agenda, which was organized 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 educators and trainers and on the current research literature. The statements were designed to generate rich descriptions of the participants' understanding and expectations of Open Dialogue approaches situated within their various work situations. In this way, participants' anticipations and assumptions could be expressed in tangible ways. As part of generating group cohesion, focusing attention and orientation to the topic, the participants were first 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 minimal throughout the focus groups as we were interested in how the participants negotiated the statements. The fifth focus group was held online because of COVID-19 restrictions.

The focus groups were audio-recorded and transcribed verbatim by a research assistant with indications of basic turn-taking features, including interruptions and overlapping speech (ten Have, 2007). The quality of the transcriptions was assessed by comparing transcriptions to audio recordings, which led to a few corrections of details of the transcripts by the research team.

Data analysis

Data analysis followed Braun and Clarke's (2006, 2020) reflective thematic analysis. This included the following: (1) Researchers, independently and as a team, familiarizing with the transcribed focus group data, (2) an open coding of the whole dataset, (3) the collation of codes into potential themes, (4) review of themes and selection of themes relevant for responding to the research questions of the current analysis, (5) further defining and naming themes, including attempts to refute the themes by re-visiting the whole data set, (6) selecting and contextualizing telling data extracts for the paper's results section.

Ethics

The University of Sydney Human Research Ethics Committee approved the study (ref. no. 2017/5883). 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 reported results.

RESULTS

In our thematic analysis of the focus group data, we developed a central theme of "Extending possibilities by holding ideas lightly." This theme was foundational to the participant's understanding of

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?

their clinical practices at the conclusion of training. We also developed two sub-themes that were constitutive of the central theme: (1) "Allowing intimacy by being aware of personal biographies," and (2) "Learning by joining others."

Extending possibilities by holding ideas lightly

"Extending possibilities by holding ideas lightly" refers to a clinical awareness described numerous times by all participants across all focus groups. It refers to a position where therapists avoid committing to one particular therapeutic approach or particular clinical assumptions and the importance of utilizing and flexibly switching between different approaches when required and thereby extending the range of therapeutic possibilities with families.

The focus groups were not designed to test participants' knowledge of Open Dialogue, and in the focus groups, participants would discuss Open Dialogue in their own words. For instance, in the post-training focus groups, Open Dialogue practices were not explicated in detail, but described with an array of metaphors and one-liners, such as "holding ideas lightly," "seeing what emerges," "slowing down," and "sitting with uncertainty," These descriptors had some manifest connections to the Open Dialogue principles, but their metaphorical open-endedness allowed for varied and idiosyncratic interpretations and applications.

In both pre- and post-training focus groups, participants described Open Dialogue as a critical and more just alternative to the dominating medical model in mental health and social care, which was seen as limited by an individualist treatment philosophy. Participants in the pre-training focus groups emphasized a need to democratize mental healthcare service delivery by not prioritizing any singular "voice" in the clinical situation, in particular therapists' or clinicians' voices. In the post-training focus groups, participants seemed to extend this to all types of authoritative "voices" including therapeutic approaches. The universal principle of participants to "hold ideas lightly" referred to clinical approaches, practices, and assessments, which could be premature and incorrect and inadvertently add to clients' problems. Paradoxically, this awareness also included being flexible and irreverent towards an Open Dialogue approach. So, despite undertaking advanced training in the Open Dialogue approach, trainees did not wholly commit to Open Dialogue at the expense of other approaches, but viewed it as just one potential treatment modality among many. Participants warned against a rigid operationalization/application of Open Dialogue, which could pervert the fundamental strengths of the approach. In the post-training focus groups, several participants stated that they had first equated Open Dialogue with a high level of commitment to the seven Open Dialogue principles, while later adopting a more flexible and pragmatic understanding of the principles and the development of several approaches to Open Dialogue.

In the following data extract from focus group #4, Libby reflects on having initially had aspirations for making organizational changes in line with the seven principles that were impossible to implement, as they were outside her sphere of influence.

> *Libby: I feel the way we've embraced Open Dialogue within our service is like family therapy, but with a bit more of a dialogical approach. Because it's been difficult to implement the systemic changes, because of all the silos within our service and all the barriers in terms of instantaneous care and continuity, psychological continuity, and all of those things. So I feel like we've embraced family therapy, and then we've put a dialogical slant on it, in terms of "let's kind of keep the agenda open" and "let's kind of make sure that it's not hierarchical" and "let's kind of maybe not be so much in control in terms of our stance." But it feels to me, more at the end of the training, like "oh, this is family therapy."*

In the data extract, Libby frees herself from the task of implementing organizational change in line with the seven principles ("instantaneous [immediate] care" and "psychological continuity") and

explains how her team's approach to family therapy had become more dialogical by emphasizing open-ended agendas, an awareness of hierarchy, and tolerating less control. In so doing, there is an acknowledgement of the dialogical approach adding something markedly different, while at the same time acknowledging the continued value of prior family therapy practices. Libby thus presents a position where she does not strictly apply all the principles of Open Dialogue but instead "holds lightly" the principles that are outside of her control and focuses on integrating aspects of a dialogical perspective into her existing family therapy practice. This position made some participants with family therapy backgrounds state that Open Dialogue presupposed an unarticulated need for family therapy skills, for instance, the ability to moderate large groups, use circular questioning, and hold multiple viewpoints.

The theme of "extending possibilities by holding ideas lightly" referred to a position where participants prioritize flexibility in their treatment approach to their work with families sometimes at the expense of fidelity to Open Dialogue. In addition, "holding ideas lightly" functioned to legitimize participants' own personal understandings of Open Dialogue texts and practices and allowed them to integrate and disregard particular aspects of Open Dialogue in line with the participants' existing treatment philosophies and local clinical practices.

Allowing intimacy by being aware of personal biographies

The sub-theme "allowing intimacy by being aware of personal biographies" accounts for trainees' intense personal experiences during the training sessions and how they increased their awareness of their personal biographies. The Open Dialogue training program required participants to reflect on and publicly present personal and emotive aspects of their psychotherapeutic work and from their family of origin. Participants reported that these aspects of training increased their awareness of personal responses that permitted greater intimacy with their clients, colleagues, and themselves.

Participants in pre-training focus groups expected to be affected personally by the training, anticipating that the training course would reduce or remove an experienced boundary between their professional and private selves, which would prepare them to talk about things from outside of their professional roles. Participants in the post-training groups reported intense experiential learning spaces during the training course, most notably during supervision and Family of Origin work, which resulted in personal transformation. These learning spaces included small group reflective processes exploring both clinical work practices and personal biographies, which allowed the participants to share personal vulnerabilities and to relate differently to other people (clients and colleagues) in a variety of contexts.

While all participants reported a willingness to deepen levels of intimacy during sessions with clients and families, participants differed markedly in how they described making use of their inner experiences. For some, the increased awareness of personal/private responses was accompanied by a preparedness to reveal inner experiences and vulnerabilities and openly integrate them into practice if it could possibly be of help to clients to hear them. For others, as in the following data extract, the awareness was primarily used to assist them in their professional reflective practices outside of therapy sessions. In the following data extract from focus group #3, Vera reflects on how sessions during the training course made her able to share more about herself, her own biography, as a way to understand challenges arising during therapy sessions. She is followed up by Gina who emphasized that her sharing of personal reactions took place after sessions:

> *Vera: I suppose the other thing I haven't said is the idea of being able to actually share with our colleagues how it was with us in the session, as far as our own family of origin or something like that. And that's probably something that I've never done before. So talking outside the session. Saying that this happened to me in a session that was something about my own family of origin that really was maybe getting in the way of the work or something like that.*

Gina: And I've also been aware that when we come out of session, when we come out of a family meeting it's less about the family and it's more about us and our reactions in the therapy process.

In this extract, Vera describes an increased awareness about her personal responses in sessions as potentially a topic for discussion outside the sessions, not in the session, and Gina follows up by explaining it as a major shift towards talking about the clinicians' reactions and responses rather than the clients' problems.

In the pre-training focus groups, several participants expressed an idea about ultimately "embodying" dialogism as a way of being, with no separation between professional, personal, and private identity, rather than mastery of a skill. This idea was not pronounced in the post-training focus groups, which could indicate a shift towards a less idealized view of what Open Dialogue approaches entail.

Learning by joining others

This theme represented the experiential learning process in Open Dialogue training that occurred extensively through group processes and created a strong sense of connection between participants. In the pre-training focus groups, participants expected to learn Open Dialogue and dialogical practices through processes of personal development and supervised practice and through reading and discussing key texts. In the post-training focus groups, these ideas were supplemented by a very strong sense of having learned in a different way: through "joining" other course participants on their personal journeys. This surprised several participants, as the traditional didactic forms of teaching involving lectures and instruction were replaced by a "hidden" element of the curriculum that *in effect* became the center of the training. Experiential group exercises required participants to find answers to their questions about dialogical work collaboratively rather than learning from an authoritative teacher's voice. Participants also reported finding support from within their groups of peers on the training courses. "Joining" with others took place in the courses' numerous and often very intimate group exercises, for example, during Family of Origin work and supervision, and established or strengthened interpersonal relationships between participants because of a greater insight into other people's psychosocial heritage. Participants said that the intimacy of dialogical training exercises, in particular during in-class reflections, allowed them as clinicians to make connections with other clinicians, which had therapeutic value.

A key part of the learning process was being asked to work in pairs or in groups, which was also reflective of the collaborative network-based approach of Open Dialogue. In the following data extract from focus group #4, Lara reflected on how her learning experiences as a trainee were transposed to practice as a clinician:

Lara: I think for me the difference that it's made comes to the level of intimacy and exposure in the room as a clinician, in working alongside another clinician. I certainly think there's a difference, because prior to that, I would predominately work alone. Now I have one or more people in the room, and I think for me personally it's meant that I've allowed myself to be much more transparent and vulnerable. Yeah. So my boundaries have shifted a bit. And I've learnt a lot more from my colleagues, because I've been exposed to their reflection, which is a different framework than the one I've got. So that's been an opportunity for me to shift professionally as well.

In the data extract, Lara links a personal and professional transformation to the social learning processes, allowing her to be witnessed by and to learn from other clinicians, on a day-to-day basis. She believes the change allows her to be more fully present in her clinical work.

Participants negotiated how to describe the learning processes. One position was to see the Open Dialogue training as "unlearning," as it entailed a major shift away from a conventional treatment

modality to working systemically/dialogically. Another position was to think of Open Dialogue as complimenting existing practices that had proved to work well rather than replacing them. Proponents of this latter position ultimately introduced the "holding ideas lightly" metaphor, which allowed them to make use of the most appropriate ideas in a concrete situation.

Dialogical learning exercises were structured in a similar way to how Open Dialogue is practiced clinically. This in effect allowed participants to become clients and therapists of other trainees providing them with a learning experience that is also a therapeutic experience. These experiences seemed to provide participants opportunity for personal transformations that carried over to a greater willingness to be more transparent and vulnerable, not only with each other but also in their clinical work with families.

DISCUSSION

The findings indicated that participants felt personally and professionally transformed by the experiential group learning processes in their Open Dialogue training. These processes promoted a feeling of connection with other trainees. Participants adopted a pragmatic position of "extending possibilities by holding ideas lightly" that allowed flexibility in taking up and modifying different therapeutic approaches and practices as required, including the Open Dialogue approach itself. This was a surprising finding for us, which suggests that the Open Dialogue training resulted in a pragmatic adoption of the philosophical tenets of the approach but, at the same time, a reduced commitment to the therapeutic model.

Our findings have a very strong resemblance to Wates (2019), Wates et al. (2022) findings from their study of Open Dialogue trainees, which was discussed under the headings: "Shifting perspectives and practice," "Deeper connections," "Experiential learning," and "Transformational learning" (these headings are, in our reading, helpful abstractions of the more descriptive headings listed in the introduction above). The significance of group practices in Open Dialogue training was also prominent in our previous focus group (Buus, Leer, et al., 2021), in which focus groups #1 and #2 were part of the data set. Here, we identified "shared concern" as a central theme, which emphasized Open Dialogue trainees' expectations of being personally committed to collaborating with clients and colleagues and appropriately sharing their professional and personal concerns. While these expectations were recognized as fulfilled by participants in the current study, participants emphasized the profound transformative effects of the training courses' group practices that allowed different expressions of intimacy and vulnerability.

Schubert et al. (2021) analyzed transformations of professional identities of psychiatrists and psychologists after they were exposed to and learned about Open Dialogue. In this study, the participating psychiatrists positioned themselves in opposition to being "fixers" of problems using a conventional medical model, and the psychologists positioned themselves in opposition to a conventional, emotionally distanced, "expert role." However, despite describing an intention and commitment to a dialogical way of working, they would construe principal external and internal limits for a full implementation of an Open Dialogue approach. In the current study, participants also negotiated the Open Dialogue principles, but with the aim of legitimizing and reinforcing eclectic psychotherapeutic practices rather than identifying limits of implementation.

Participant's use of the phrase "holding ideas lightly" can be linked to Bakhtin's metaphor of "polyphony" (Bakhtin, 1984), which is often referenced in the core Open Dialogue literature. The concept of polyphony proposes that all voices in a social space are autonomous, unmerged, and have equal weighting. Similarly, Anderson (2005), Anderson & Goolishian (1992) notion of "not-knowing" emphasizes that therapists' voices represent only a limited specific perspective on a situation. "Holding ideas lightly" thus represents a shorthand description of a number of concepts across different dialogical approaches. However, "holding ideas lightly" is also consistent with post-Milan family therapy where the concept of "irreverence" – that therapists must stay dis-loyal and "not fall in love"

with their hypothesis (Cecchin et al., 1992) – has been promoted as a way to encourage therapists' curiosity and to mitigate potential negative effects of unhelpful, and potentially violent, hypothesizing. "Holding ideas lightly" may thus represent a moral position held by participants that is not restricted to only dialogical approaches. Instead, a commitment to flexibility in applying therapeutic approaches and a willingness to put aside one's own perspective and knowledge with the intention of providing what is best for the client. "Holding ideas lightly" is closely aligned with the values of collaborative approaches more generally, as opposed to more authoritative approaches such as various forms of structural, strategic, and even systemic and Bowen family systems approaches, which can present stricter guidelines and goals for family therapy practice (Brown, 1999; Hayes, 1991). Interestingly, by taking a flexible and irreverent approach to therapeutic models suggested by "holding ideas lightly," therapists essentially reserve the right to adopt these more directive approaches if deemed necessary. We do not know if the emphasis on "holding ideas lightly" was an intended learning outcome or a unique product of these particular Australian training courses where trainees eclectically drew on and merged ideas from numerous therapeutic approaches.

To our knowledge, Open Dialogue training programs do not explicitly refer to a specific learning philosophy. In Wates (2019), Wates et al. (2022) study, participants reported that they felt more confident in questioning hierarchies and power relationships. This made Wates et al. suggest parallels between the Open Dialogue learning processes and Freire's (2005) tenets about raising students' critical consciousness. While Freire's notion of 'dialogics' is very different from "dialogism," Wates et al.'s reading of Open Dialogue learning processes links the approach to political commitment to democratizing knowledge and addressing inequities in service delivery, see also (Buus, Leer, et al., 2021). In this context, Open Dialogue becomes inseparable from a social justice agenda.

Open Dialogue training programs are often positioned as distinctly different from traditional didactic-style learning and are based on an unstructured and highly experiential approach to learning (Buus, Leer, et al., 2021). Considering the social and individual transformational effects of the group-based training programs, we suggest viewing them from a social learning perspective (Lave & Wenger, 1991). Lave and Wenger's (1991) book *Situated Learning* sparked a global interest in apprenticeship learning processes. The core idea is that members of a community of practice gradually move from legitimate peripheral participation to full participation. "Learning in practice" is concerned with people's ability to engage in shared practices, their shared development of understanding of why they engage in it, and the shared resources they have at their disposal to negotiate them (Wenger, 1998). Active participants in shared practices can, according to Wenger (1998), generate collective learning, which forms "communities of practice" and informs participants' identities. In the current study, participants reported continually sharing high levels of vulnerability in the training course practices. This occurred not only through shared personal biographies and having greater insight into others' psychosocial heritage through Family of Origin work, but also when sharing videos of network meetings and having practice critiqued during group-based supervision. Viewing Open Dialogue training from a situated learning perspective can explain the participants' foregrounding of embodied shared experiences and their metaphorical descriptions of their practices. Participants were not learning how to practice a therapeutic technique or propositional knowledge; rather, they were socialized into therapeutic practices with a strong focus on "withness-thinking" (Shotter, 2011) and developed strong community identities and sense of belonging. Finally, viewing Open Dialogue training from a situated learning perspective raises important questions about the effects of delivering short courses, where communities of practice are not established, or where more didactic approaches to teaching Open Dialogue are implemented, which might have very different learning outcomes than the ones modeled on the Finnish approaches.

The reported transformative effects of participating in the training course are most probably not unique for Open Dialogue. Reflective training processes, such as peer discussions, reflecting team exercises, and personal family-of-origin work, are frequently also central in more conventional courses. Studies of more conventional family therapy training have indicated that trainees' experi-

enced personal and professional change as a result of engaging with reflective processes and that this reflective form of learning had altered their worldview and understandings of themselves and relationships with others, see for instance (Fragkiadaki et al., 2013; Givropoulou & Tseliou, 2021; Rhodes et al., 2011). In line with our study, these studies have also emphasized the importance of establishing trust and safety between trainees and the resulting community of practice, which fosters a sense of belonging, acceptance, and support from fellow trainees (Fragkiadaki et al., 2013; Givropoulou & Tseliou, 2021). More research is needed to explore similarities and differences in learning processes and outcomes between these approaches.

Limitations

Our approach includes elements of "insider research" (Allen, 2004), as NB and AM were both participants in the 3-year training course as well as members of the research team designing and conducting the study. On the one hand, this position provided us with unique contextual knowledge. It facilitated access to the field, including well-established, trusting relationships with participants and personal insights into Open Dialogue learning processes. On the other hand, it could "naturalize" the field and make us oversee significant elements during focus groups and in the following analyses. This challenged us to continually question our taken-for-granted assumptions (that would sometimes be shared with the study participants) by systematically exploring outliers and negative cases and comparing our developing interpretations to other studies (inside and outside Open Dialogue).

Readers should be cautious if they wish to transfer the findings of this study to other Open Dialogue, or family therapy, training contexts. While the courses were modeled on previous courses developed in Finland, the actual delivery did not follow a structured format, and different teachers using the same curriculum with a different group of trainees might generate very different experiences of learning processes and outcomes. Finally, it was not feasible to recruit the exact same study participants at both the pre- and post-training focus groups, and it is possible that a more complete group of participants could have given us additional insight into individual participant's learning experiences over time. A study of course dropouts, for instance, could provide more nuanced insights into trainees' experiences, including some of the negative, frustrating experiences also reported in the literature (Pope et al., 2016; Stockmann et al., 2017; Wates et al., 2022).

CONCLUSION

This study highlights some of the unexpected outcomes of an Open Dialogue training program that eschews traditional teaching approaches and focuses on experiential processes that mirror the processes and practices in Open Dialogue clinical practice. Participants gained direct experience of what it was to be a client in a dialogical approach. This sort of training produced some unexpected outcomes such as "extending possibilities by holding ideas lightly" where participants developed their own understandings of dialogical principles with a greater emphasis on flexibility in their clinical approach.

This has implications for other family therapy training programs. Trainers can consider whether their training programs are consistent with the underlying assumptions of the approach. In addition, this research encourages consideration of how group-learning processes are conducted. Group learning processes focusing on skills acquisition may provide trainees with opportunities to learn and practice skills. However, by incorporating practice situations where trainees have some personal or emotional connection to the topics being discussed can have a therapeutic and transformative effect that may have a wider impact on the personhood of the trainee as well as contribute to an emotional togetherness and sense of community in the trainee group.

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