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The Open Dialogue Approach to Mental Health Care

Study 1: A systematic review of Open Dialogue studies involving primary data collection.

Study 2: Practitioner perspectives on Trauma Informed Care and the Open Dialogue approach to mental health care.

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Thesis submitted to UCC in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology, School of Applied Psychology, University College Cork, Cork, Ireland.

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Head of School: Professor John McCarthy

September 2019

Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signature:

Dan Hartnett 10/09/19.

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Study 1: A systematic review of Open Dialogue studies involving primary data collection.

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Running title: Open Dialogue.

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Prepared in accordance with author guidelines for Early Intervention in Psychiatry (See Appendix B). Tables and figures are presented in text for ease of examination.

Abstract

Aim: Open Dialogue (OD) is a family- and social network-based approach to the treatment of psychosis and other serious mental health difficulties. Previous reviews were conducted some time ago and included discussion papers and case composites. A criticism of the literature base with regard to the model has been its lack of focus on primary research. The aim of the present study was to thus provide a current and comprehensive review of OD studies which involved primary data collection**. Methods:** Studies were identified through electronic searches using Psycinfo, Science Direct, and PubMed, as well as reference harvesting. Following initial screening of irrelevant studies, potentially eligible papers were independently identified by the first and second authors. Study quality assessment tools were also applied to papers selected for inclusion in the review. **Results:** 15 papers involving 16 studies were identified; 8 studies described OD outcomes, while 8 described qualitative therapeutic process or implementation studies. Reported outcomes were generally positive on a number of key variables such as psychotic symptomatology and service utilisation. Qualitative studies pointed toward a high degree of staff and service user acceptability, and highlighted a number of important process issues, and implementation challenges. Study quality for qualitative studies was generally good, but the quality of outcome studies was assessed as poor. **Conclusions:** Emerging evidence exists with regard to the effectiveness and acceptability of OD. Therapeutic processes and implementation issues appear well-elucidated. However, it is difficult to make strong conclusions with regard to outcome data due to poor study quality.

Introduction

Open Dialogue (OD) is a family- and social network-based approach to the treatment of psychosis and other serious mental health difficulties. OD does not emphasise medication as an intervention. Rather, an individualised plan for recovery is developed for each service user, with psychotherapeutic treatment delivered within the context of their own support network (Seikkula, Alakare, & Aatonnen, 2001; Seikkula et al., 2006). The approach has its roots in the Need Adapted Approach (NAA) which was first implemented in Turku, Finland in the 1980's. In 1982, the positive outcomes associated with NAA in comparison with treatment as usual (TAU), led to a reorganisation of psychiatric services in the region such that all referrals were treated in line with the NAA principles from that time (Gromer, 2012). Like OD, the NAA espoused a flexible, individualised social network-based approach to treatment (Lehtinen, 1993). However, the OD approach built upon these principles through the addition of mobile crisis intervention teams and the introduction of a particular emphasis on the promotion of 'dialogic' communication during network meetings; 'dialogic' here referring to a focus on creating dialogue where a new understanding is constructed with the team, while promoting a sense of agency and change for the service user and their family (Freeman et. al., 2018). These developments occurred over a number of years in the Western Lapland region of Finland and involved the introduction of psychotherapy training for all mental health services staff. In addition, a substantial re-organisation of services was undertaken to place greater emphasis on individually responsive community treatment (Aaltonen, Seikkula, & Lehtinen, 2011).

As OD developed, seven key elements were articulated which have come to define the overarching principles of the approach (Olson, Seikkula, & Ziedonis, 2014): (1) *immediate help*, whereby an initial meeting should occur within the first 24 hours of

referral with the aim of reducing the likelihood of a hospital admission, (2) *a social network perspective*, which involves inviting key members of the referred individual's social network to participate in network meetings, (3) *flexibility and mobility*, where treatment is tailored in a flexible way to meet the changing needs of the individual, in a location which is convenient and acceptable to them, typically within their own home and over a number of days if necessary (4) *responsibility*, whereby the clinician who makes first contact with the referred individual, irrespective of their professional role, takes responsibility for organising the first meeting, and following this the treatment team collaboratively take responsibility for further care, (5) *psychological continuity*, whereby, insofar as is possible, the composition of the individual's treatment team remains the same throughout their journey through the mental health service, (6) *tolerance of uncertainty*, which involves avoiding premature decisions about treatment such as the necessity for neuroleptic medication, and (7) *dialogism*, which, as perviously noted, refers to the attempt within treatment meetings to generate therapeutic dialogue between those present, allowing for multiple perspectives to emerge and the generation of a shared language and understanding regarding the presenting difficulties.

In recent years, the OD approach has been implemented in a number of locations worldwide such the United Kingdom, Denmark, Norway, Sweden, and the United States (Buus et al., 2017; Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016). As a principles-based approach requiring both individual level and systemic change, some have highlighted the fact that there is considerable heterogeneity in terms of how the OD approach is implemented in each individual location. This poses difficulties when attempting to review the literature (Lakeman, 2014). In addition, Seikkula, Alakare, & Aaltonen (2011) highlight the contrast between traditionally designed outcome studies

of therapeutic interventions involving a similar treatment modality for each referred individual and the OD approach of tailoring therapeutic input for each participant. This makes the evaluation of the approach through traditional designs difficult. Notwithstanding these difficulties, a number of attempts have been made to describe the evidence base with regard to OD. Gromer (2012) for example, conducted a systematic review of outcome studies relating to OD and NAA concluding that there is good evidence to suggest these approaches are effective in reducing the frequency of relapses, hospital admissions, and the need for neuroleptic medication, as well as increasing indices of social functioning. Lakeman's (2014) narrative review attempted to examine the evidence for the effectiveness of the OD approach as well as to identify its critical ingredients. He concluded that the literature pointed toward promising outcomes, but that more rigorous studies were needed both to establish the effectiveness of the approach and to discern whether it is the OD elements of treatment packages which are leading to positive outcomes. Finally, Buus et al.'s, (2017) review outlined the development of OD in Scandinavia finding the studies identified characterised by small sample sizes, heterogeneity of implementation types, and poor fidelity checks. Nevertheless, the authors suggest that the identified literature described OD as a welcome alternative to conventional mental health service delivery by professionals, service users, and their families. A number of difficulties were also highlighted however, such as resistance to implementation from practitioners in the context of role changes as a result of OD implementation, and some families reporting discomfort with the group format of network meetings.

While helpful, the above reviews were conducted some time ago and so do not include more recent studies. In addition, none include a formal assessment of study quality using a robust assessment tool. Further, previous reviews have tended to include papers

such as discussion pieces and illustrative composite case studies in which no primary research was conducted. This lack of focus on primary research has been criticised by some authors as a weakness with regard to the OD evidence base (Torrey, 2011). The aim of the present review is thus to provide a current and comprehensive review of OD studies which involved primary data collection.

Method

Search strategy

Studies were identified through electronic searches and reference harvesting conducted by the first author with support from the second author. An electronic search using Psycinfo, Science Direct, and PubMed with the following search terms: "open dialogue approach or open dialogue or open dialogue therapy or open-dialogue approach or open-dialogue or open-dialogue therapy" was initially conducted by the first author. These databases were chosen as they had been used in a number of other relevant previous systematic reviews (Buus et al., 2017; Gromer, 2012). The search terms used were identified following input from the subject expert librarian at the university with which the first and third authors are affiliated. Search terms were formulated to be deliberately broad in order to maximise the possibility of locating relevant papers. OD was first developed in the 1980s and so, as papers which were published before this time were likely to be irrelevant, the electronic search was restricted to 1980 onwards. The final electronic search was completed on 21st September 2018. Following the electronic search relevant previous reviews were examined for potentially relevant papers. Results of the electronic and reference harvesting search were initially screened by title and abstract by the first author and duplicate and obviously irrelevant papers excluded. Remaining papers were independently assessed by the first and second authors for inclusion with 83% agreement achieved, and disagreements settled by consensus. In line

PRISMA guidelines for the reporting of systematic reviews (Moher et al., 2009), Figure 1 depicts the flow of papers during each phase of the search process.

Inclusion and exclusion criteria

In order to maximise the breath of studies included, papers involving adults experiencing any mental health difficulty were included in the review as were papers relating to OD practitioners or trainees. Only papers which described studies which self-identified as being related specifically to the OD approach as defined by Seikkula et al.'s (2001) seven key principles were included. Papers describing studies relating to any other intervention, dialogic practice more generally, or where OD was offered in combination with another intervention were excluded. Papers describing studies in which primary data collection did not occur, such as case studies and discussion papers were also excluded.

Study quality assessment

Separate quality assessment tools were used for qualitative and quantitative studies. For qualitative studies a scoring system based on the Critical Appraisal Skills Programme qualitative checklist (CASP; Critical Appraisal Skills Programme, 2018) was constructed following guidance from Buttler, Hall, & Copnell (2016), whereby a range of points (1 for yes, 0.5 for unsure, and 0 for no) were applied to each item on the tool in respect of each individual study assessed. This provided a numerical indication of study quality under the tool's three key question domains, 'are the results of the study valid?', 'what are the results?', and 'will the results help locally?', the summation of which provided a global numerical indication of study quality ranging from 0 to 10. For quantitative studies the Quality Assessment Tool for Quantitative Studies (QATQS; Effective Public Health Practice Project, 1998) was used. This tool was chosen as it can

be applied to a wide range of quantitative designs while at the same time demonstrating equivalency to more frequently used tools (Thomas, Ciliska, Dobbins, & Micucci, 2004). The QATQS requires the assessor to examine each individual study under the seven separate domains of 'selection bias', 'study design', 'confounders', 'blinding', 'data collection methods', 'withdrawals and dropouts', and "data analysis methods" and indicate the study's quality as either 'good', 'fair', or 'poor' in each domain. Both assessment tools were applied to each paper by the first author.

Results

Fifteen papers were identified though the electronic search and reference harvesting for inclusion in the review; one dual study mixed methods paper and 14 single study papers. Papers were categorised on the basis of whether they described OD outcomes, or whether they described OD therapeutic processes or implementation. Eight OD outcome studies were identified. Seven related to three Finnish cohorts (Aaltonen et al., 2011; Bergström et al., 2017, 2018; Seikkula et al., 2006; Seikkula et al., 2003; Seikkula, Alakare, & Aaltonen, 2001; Seikkula et al., 2011), while one related to a cohort from the United States (US; Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016). Eight studies describing OD therapeutic processes and implementation were identified. Three of these papers related to staff and service user experiences of the implementation of OD (Gordon et al., 2016; Holmesland, Seikkula, Nilsen, Hopfenbeck, & Erik Arnkil, 2010; Piippo & Aaltonen, 2004), while five described therapeutic processes (Holmesland, Seikkula, & Hopfenbeck, 2014; Lidbom, Bøe, Kristoffersen, Ulland, & Seikkula, 2014, 2015; Piippo & Aaltonen, 2008; Seikkula et al., 2001). Study characteristics, key findings, and study quality assessment are presented in Tables 1 and 2 above, and in narrative format below.

Outcome studies: Finnish cohorts

One paper was identified which described outcomes relating to the Finnish *Western Lapland Project* (WLP-OD cohort; Aaltonen et al., 2011). This paper compared outcomes for 111 cases who received treatment within the principles of OD as part of that project to a historical comparison group of 139 cases who received TAU in the same area before the OD approach was implemented. Participants were individuals experiencing first episode prodromal or overt psychosis with no previous contact with mental health services. At the four-year follow-up point, significant differences were observed between the groups on schizophrenia diagnoses and brief psychotic reactions such that the WLP-OD cohort displayed higher rate of brief psychotic reactions, but a lower incidence of schizophrenia diagnoses compared to those who received TAU. The authors suggest that these findings support their hypothesis that OD lead to a reduction in brief psychotic reactions developing into more chronic difficulties.
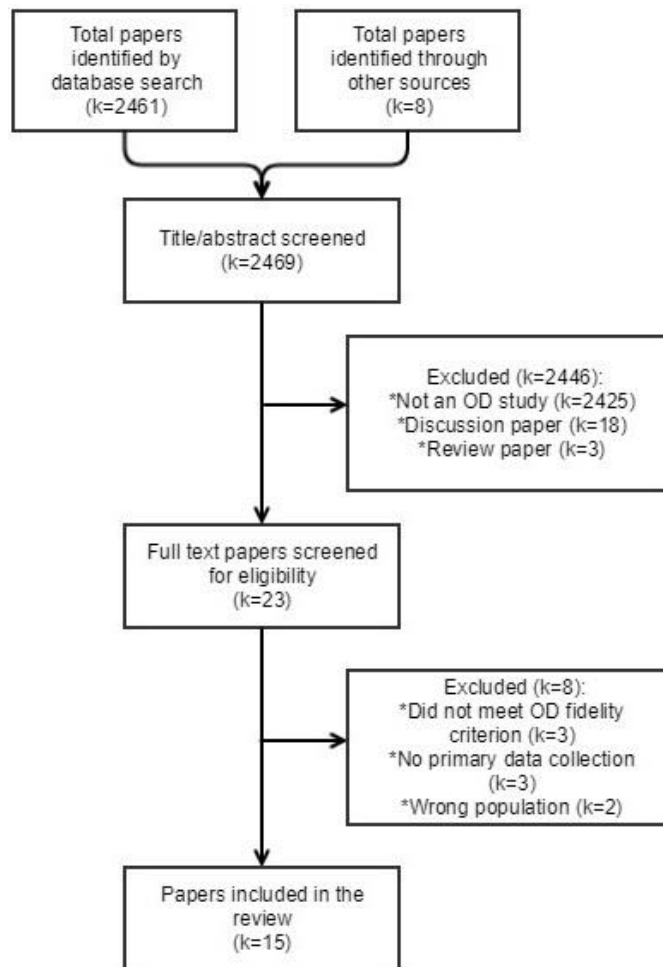
Figure 1: Flow of papers though each phase of the search process.

Table 1. Study characteristics, results, and study quality assessment for quantitative studies included in the review.

First author (year) (location)	Sample characteristics	Measures	Assessment occasions/ Follow-up period(s)	Results	Study quality assessment					
					SB	SD	CF	BL	DC	WD
Aaltonen (2011) (Finland)	WLP-OD; consecutively admitted cases to Western Lapland mental health services experiencing symptoms of prodromal and overt psychosis with no previous history of involvement with psychiatric services receiving treatment within the principles of OD between 1990 and 1994; *n*=111. TAU; historical control group consisting of similar cases accessing Western Lapland mental health services between 1985 and 1989 receiving treatment-as-usual; *n*=139.	a. Schizophrenia diagnosis. b. Brief psychotic reactions. c. Other non-affective psychoses. d. Prodromal states.	4-year.	a. WLP-OD (10.4) < TAU (24.5)*** b. WLP-OD (6.7) > TAU (1.2)** c. NS. d. NS.	G	F	P	P	F	G
Bergstrom (2018) (Finland)	OD-III; mixed sample of first episode cases receiving treatment within the principles of OD in the Western Lapland region as part of the API cohort between 01/01/92 and 31/03/93, the ODAP-I cohort between 01/01/94 and 31/03/97, the ODAP-II project between 01/02/03 and 31/12/05; *n*=108. TAU; All Finish first episode psychosis patients with a similar follow-up period whose first psychiatric treatment was delivered outside of the Western Lapland region and thus not within the principles of OD; *n*=1763.	a. Total deaths. b. Deaths by suicide. c. Deaths by natural causes. d. Hospital Tx > 30 days. e. Hospital re-admissions. f. Treatment contact at follow-up. g. Neuroleptic use at onset. h. Neuroleptic use at some point. i. Neuroleptic use at follow-up. j. Disability allowance at some point. k. Disability allowance at follow-up.	19-year.	a. NS b. NS c. NS d. OD-III (18.5%) < TAU (94.4%)*** e. OD-III (45.4%) < TAU (90.5%)*** f. OD-III (27.8%) < TAU (42.9%)** g. OD-III (20.4%) < TAU (70.1%)*** h. OD-III (54.6%) < TAU (97.3%)*** i. OD-III (36.1%) < TAU (81.1%)*** j. OD-III (41.7.%) < TAU (78.8%)*** k. OD-III (33%) < TAU (61%)**	G	F	P	P	G	G

| Bergstrom (2017) (Finland) | First episode psychosis cases receiving treatment within the principles of OD in Western Lapland between 1992 and 2015 as part of the API, ODAP-I, and ODAP-II cohorts; *n*=65 | a. Hospital admissions.
b. Number of hospital days.
c. Number of outpatient visits.
d. Length of treatment (years).
e. Neuroleptic commencement at outset.
f. Ongoing neuroleptic use.
g. Occasional neuroleptic use.
h. No neuroleptic use. | 10 to 23 years depending on cohort. | a. 0-1, 54%; 2-3, 18%; 4-9, 18%; >10, 9%; Participants who displayed physical aggression at outset were more likely to be hospitalised (*M*=4.7 *SD*=3.8 Vs. *M*=2.1 *SD*=3.4)**; Participants who were hospitalised at outset had more re-admissions and longer duration of Tx than those who were not (*M*=5.4 *SD*=4.8 Vs. *M*=1.5 *SD*=2.2***; *M*=9.5 *SD*=6.6 Vs. *M*=5.6 *SD*=5.8*).
b. 0, 29%; 1-7, 17%; 8-30, 15%; >31, 38%
c. 1-19, 54%; 20-79, 42%; >80, 5%.
d. < 5, 53%; > 5, 48%. Participants who displayed physical aggression at outset had a longer duration of Tx than those who did not (*M*=10.3 *SD*=7.3 Vs. *M*=6 *SD*=5.9)**
e. Yes, 26%; No, 74%. Participants who commenced neuroleptics at outset had more re-admissions and longer duration of Tx than those who did not (*M*=6 *SD*=4.9 Vs. *M*=1.5 *SD*=2.2***; *M*=11 *SD*=5.7 Vs. *M*=5.4 *SD*=5.9***).
f. 15%
g. 40%
h. 45% | F | F | P | P | G | F |

Study	Sample	Measures	Time points	Results						
Gordon (2016) (United States)	Cases involving individuals voluntarily or involuntarily presenting to emergency services experiencing psychotic symptoms with no current substance misuse difficulties, developmental/neurological disabilities, or issues of risk which would require inpatient care; n=14.	a. Hospitalisation days. b. BPRS. c. BAIS-R. d. SCLFS. e. DSES. f. Average work/school days per month.	T1: BL. T2: 3-month. T3: 6-month. T4: 12-month.	a. T1 (M=15.29; SD=21.80) > T3(M=2.79; SD=7.15) > T4 (M=1.64; SD=3.66)* b. T1 (M=58.79; SD=16.57) > T2(M=43.88; SD=11.67) > T3 (M=38.88; SD=11.14) > T4 (M=33.33; SD=10.10)***. c. T1 (M=1.52; SD=0.59) > T2(M=1.06; SD=0.62) > T3 (M=0.82; SD=0.63) < T4 (M=0.95; SD=0.68)**. d. T1 (M=2.02; SD=0.56) > T2(M=2.84; SD=0.40) > T3 (M=2.84; SD=0.69) < T4 (M=3.22; SD=0.68)***. e. NS. f. T1 (M=32; SD=58.87) < T3(M=98.86; SD=62.80) < T4 (M=122.18; SD=57.37)***	F	F	P	P	G	F
Seikkkula (2011) (Finland)	API; first contact cases receiving a need adapted but not intentionally dialogic treatment between 01/04/92 and 31/12/93; n=33. ODAP-I; first contact cases receiving a well-developed version of OD between 01/01/94 and 31/12/97; n=43. ODAP-II; first contact cases receiving a well-developed version of OD between 01/01/03 and 31/12/05; n=18.	a. Hospitalisation days. b. Neuroleptic medication commencement. c. Ongoing neuroleptic medication use. d. Number of relapsed service users. e. Employment status. f. Number of network meetings. g. BPRS. h. SCS. i. Duration of untreated psychosis.	BL. 2-Year.	a. ODAP-II (M=13.6; SD=27.8) < API (M=25.7; SD=44.2)*** b. NS. c. NS. d. NS e. NS f. NS g. ODAP-II (M=23.7; SD=4.5) > ODAP-I (M=28.5; SD=8.8)*** h. API (M=0.50; SD=0.90) > ODAP-I (M=0.30; SD=0.70)** ODAP-II (M=0.5; SD=0.9) < ODAP-I (M=3.3; SD=3.8)***	F	F	F	P	G	G

| Seikkula (2003) (Finland) | ODAP-I; first contact cases diagnosed with a psychotic disorder receiving a well-developed version of OD between 01/01/94 and 31/12/97; $n=23$[1].

TAU; first contact cases from a traditional service diagnosed with a psychotic disorder receiving treatment-as-usual between 01/04/92 and 31/12/93; $n=14$[1].

API; first contact cases diagnosed with a psychotic disorder receiving a need adapted but not intentionally dialogic treatment between 01/04/92 and 31/12/93; $n=22$[1]. | a. Hospitalisation days.
b. Neuroleptic medication commencement.
c. Ongoing neuroleptic medication use.
d. Number of relapsed service users.
e. Employment status.
f. Number of network meetings.
g. BPRS.
h. SCS.
i. Number receiving individual psychotherapy.
j. GAF. | BL
2-Year. | *Differences between groups at T2:*
a. API (M=35.9; SD=44) < TAU (M=116.9, SD=102.2)**
b. API (36%) < TAU (100%)***
c. API (23%) < TAU (71%)*
d. API (36%) < TAU (71%)*
e. ODAP-I (83%%) > TAU (21%)***
f. API (M=26.1; SD=14.1) < TAU (M=8.9, SD=6.2)***
g. API (M=35.9; SD=44) > ODAP-I (M=35.9; SD=44)*
h. ODAP-I (0-1, 83%; 2-4, 17%) < TAU (0-1,50%; 2-4, 50%)*
i. NS.

Analysis of change from T1-T2:
h. API = ODAP-I > TAU**
j. API = ODAP-I > TAU*** | P | P | P | P | G | G |
| Seikkula (2006) (Finland) | ODAP-I; first contact cases receiving a well-developed version of OD between 01/01/94 and 31/12/97; $n=42$.

API; first contact cases receiving a need adapted but not intentionally dialogic treatment between 01/04/92 and 31/12/93; $n=33$. | a. Hospitalisation days.
b. Neuroleptic medication commencement.
c. Ongoing neuroleptic medication use.
d. Number of relapsed service users.
e. Employment status.
f. Number of network meetings.
g. BPRS.
h. SCS
i. Duration of untreated psychosis. | PT
2-year.
5-year. | a. *T2:* ODAP-I (M=9.3; SD=18.3) < API (M=25.7; SD=44.2)***;
T3: NS.
b. *T2*: NS; *T3*: NS.
c. *T2*: NS; *T3*: NS.
d. *T2*: NS; *T3*: NS.
e. *T2*: NS; *T3*: NS.
f. *T2*: NS; *T3*: ODAP-I M=3.8; SD=7.9) < API (M=10.6; SD=16.3)***
g. *T2*: ODAP-I (M=23.7; SD=4.5) < API (M=30.2; SD=12.9)***;
T3: NS.
h. *T2*: NS; *T3*: NS
i. NS | G | F | P | P | G | G |

| Seikkula (2001) (Finland) | First episode cases receiving treatment within the principles of OD in the Western Lapland region between 1992 and 1997 categorised into good outcome cases (GO; n=61), and poor outcome cases (PO; n=17) on the basis of psychosocial functioning and level of residual symptomatology. | a. Demographic characteristics.
b. Social network quality.
c. Employment status.
d. Diagnoses.
e. GAF.
f. BPRS.
g. Duration of untreated psychosis (months).
h. Duration of prodromal symptoms (months).
i. Hospitalisation days
Use of neuroleptics. | 5-year | a. NS
b. GO (76.9%) > PO (29.4%)***
c. GO (95%) > PO (64.7%) ***
d. GO (27.9%) < PO (88.2%)***
e. NS
f. NS
g. GO (M=2.5; SD=4.1) < PO (M=7.6; SD=7.6)***
h. GO (M=7; SD=17) < PO (M=26.7; SD=29.4)***
i. GO (M=9; SD=19.2) < PO (M=47.5; SD=56)***
j. GO (19.7%) < PO (52.9%)*** | G | F | F | P | G | G |

Note: *=p<0.05; **=p<0.01; ***=p<0.001; WLP-OD= Western Lapland Project OD cohort; API=Acute Psychosis Integrated treatment cohort; ODAP-I=Open Dialogue in Acute Psychosis cohort one; ODAP-II= Open Dialogue in Acute Psychosis cohort two; OD-III=combined API/ODAP-I/ODAP-II cohort; TAU= treatment as usual; NS= non-significant; OD=Open Dialogue; T=time; BPRS=Brief Psychiatric Rating Scale; BIAS-R=Revised Behaviour and Symptom Identification Scale; SCLFS=Strauss-Carpenter level of Function Scale; DSES=Decision Self Efficacy Scale; SCS= Strauss-Carpenter Rating Scale; GAF= Global Assessment of Function; M=mean; SD=standard deviation; [1]= severe cases excluded from this sample; G=good; F=fair; P=poor; PT=pre-treatment; BL=baseline; SB=Selection bias; SD=Study design; CF=Confounders; BL=blinding; DC=data collection; WD= withdrawals.

Table 2. Study characteristics, key findings, and study quality appraisal for qualitative studies included in the review

First author (year) (location)	Sample characteristics	Aim	Methods	Findings	Study quality assessment			
					VL	RS	LH	GL
Gordon (2016) (United States)	Cases involving individuals voluntarily or involuntarily presenting to emergency services experiencing psychotic symptoms with no current substance misuse difficulties, developmental/neurological disabilities, or issues of risk which would require inpatient care; *n*=6. Staff members involved in the project working within the principles of OD; *n=8*	To assess the feasibility of implementing OD in a US context.	Qualitative interviews.	*Service users and their families:* a. Openness and transparency of the approach appreciated. b. Felt "cared for" and "not on the clock". c. Appreciated that treatment was not solely focussed on medication but lack of clear focus on medication highlighted as a difficulty. d. Two families highlighted a need for supplementary social services. *Staff members:* e. Better able to engage service users and their families. f. Enjoyed working in this modality. g. Modality supported non-hospital options by affording support and safety. h. Scheduling of urgent network meetings while managing other cases a concern for some.	5/6	1/3	1/1	7/10
Holmesland (2010) (Norway)	Health care, and social and educational professionals who had participated in multi-agency/professional network meetings while working within the principles of OD; *n*=12	Explore challenges to professional identity in multi-agency/professional network meetings.	Focus groups analysed using content analysis.	a. Some participants were successful in changing their roles, while others found this process more difficult and reverted to their traditional professional role. b. Health and social care professionals felt marginalised due to issues surrounding professional competence and legitimacy. c. Personality factors were highlighted as important prerequisites to successful collaboration. d. For both groups, working transdisciplinarily lead to greater knowledge of each other.	6/6	2/3	1/1	9/10

Holmesland (2014) (Norway)	Health care, and social and educational professionals who had participated in multi-agency/professional network meetings while working within the principles of OD; *n*=12	Examine professionals' understanding of what promotes or impedes dialogue in inter-agency network meetings and how this is related to their professional backgrounds.	Focus groups supplemented with network meeting transcripts analysed using content analysis.	a. The importance of creating an atmosphere where all participants felt listened to, and where solutions were not too hastily suggested was highlighted. b. The need for self-disclosure in creating an atmosphere of authenticity was discussed. c. Social and educational personnel appeared to be less experienced in how to present their own in-session emotional reactions in a way that promoted dialogue when compared to health worker colleagues.	5/6	2/3	1/1	8/10
Lidbom (2014) (Norway)	A mother, her son and two network therapists participating in an OD network meeting; *n*=4.	To explore inner and outer dialogue in OD network meetings.	Video recorded network meetings supplemented with interviews focussing on video content analysed using a bespoke method.	a. The same outer dialogue evoked different inner dialogues among participants which in turn contributed to the generation of new meaning and perspectives in further outer dialogue. b. The interplay between inner and outer dialogue was more important than the number of utterances within the therapeutic conversation in terms of generating significant and meaningful moments.	5/6	2/3	1/1	8/10
Lidbom (2015) (Norway)	Adolescents and their networks participating in OD network meetings; *n*=6	To explore how participants' inner dialogues contribute to significant and meaningful moments in network meetings.	Video recorded network meetings supplemented with interviews focussing on video content analysed using a bespoke method.	a. Inner dialogues contributed as much as outer dialogues in terms of generating significant and meaningful moments. b. Inner dialogues were important in facilitating participants to consider alternative positions. c. When dialogue was monologic participant tended to withdraw from the therapeutic conversation into inner dialogue.	5/6	3/3	1/1	9/10

| Piippo (2008) (Sweden) | Individuals who had experienced both TAU and OD as part of the same Swedish OD implementation; *n*=22 | To examine how trust and mistrust are created within TAU and OD. | Interviews analysed using grounded theory. | a. In OD trust is created in the honest reciprocal cocreation of knowledge in network meetings.
b. Feeling being influenced too much by staff and excluded lead to feelings of mistrust in OD.
c. Feelings of exclusion and confusion were also said to reduce autonomy.
d. In TAU trust was related to being treated as an individual in a respectful way.
e. Mistrust in TAU was created through the undervaluation of participants' understandings.
f. Depersonalisation of the individual was also related to mistrust in TAU. | 6/6 | 3/3 | 1/1 | 10/10 |
| Piippo (2004) (Sweden) | Individuals who had experienced both OD as part of the same Swedish OD implementation; *n*=22 | To describe how service users had experienced a Swedish OD implementation. | Interviews analysed using grounded theory. | a. Positive factors included: having all important persons in the room at the same time, feeling free to say what one wants to say, seeing problems from several points of view, and having an experience of co-operation instead of objectification.
b. Ambivalent factors included: doubts about the permanency of OD related changes and worrying about the feelings of other invited network members in the room.
c. Negative aspects included: professionals becoming overly enthusiastic about OD or becoming excessively abstract and distant from the lived experience of their lives. | 6/6 | 3/3 | 1/1 | 10/10 |

| Seikkula (2002) (Finland) | Matched cases with good (n=10) and poor (n=10) outcomes drawn from the API cohort and ODAP1 cohorts described in Table 1 above; *n*=30. | To describe dialogues generated in network meetings and provide contrasting examples of "dialogical" and "monological" dialogues in good and poor outcome cases. | Transcripts of first two or three initial network meetings analysed using sequence analysis. | a. In good outcome cases theme sequences appeared to be longer.
b. In the good outcome group clients and their families displayed interactional dominance more often than was observed in the poor outcome group.
c. Clients and their families displayed semantic dominance in the majority of sequences in the good outcome group, with more variation evident in poor outcome cases.
d. Good outcome cases displayed more symbolic language use. Where indicative language was used this appeared to act as a barrier to dialogic conversation. | 5/6 | 3/3 | 1/1 | 9/10 |

Note: OD=Open Dialogue; US=United States; VL=validity domain; RS=results domain; LH=local help domain; GL=global Critical Appraisal Skills Programme score; TAU=treatment as usual.

Two papers were identified which provide 2- and 5-year follow-up outcome data for participants associated with the *Open Dialogue in Acute Psychosis Project* (ODAP-I cohort; Seikkula et al., 2006; Seikkula et al., 2003). In Seikkula et al.'s (2003) study, 23 first contact cases diagnosed with a psychotic disorder receiving treatment within the principles of OD between 1994 and 1997 at an implementation site in Western Lapland were compared at 2-year follow-up to two matched groups of similar cases. One group involved 14 individuals receiving treatment as part of the Acute Psychosis Integrated Treatment (API) project which represented a less developed form of OD in which a dialogic approach to network meetings was not emphasised. The other group involved 14 individuals who received TAU in a different but ethnically similar location in Finland. Statistical comparisons were firstly made between the API group and TAU group, and if non-significant between the ODAP-I and TAU group. The API group displayed significant positive outcomes relative to TAU on hospitalisation days, neuroleptic medication use, and number of relapses. The ODAP-I group faired significantly better than TAU on employment status with 83% of participants studying, working, or job seeking at 2-year follow-up in the ODAP-I group, compared to 30% who received TAU. Both the API and ODAP-I groups displayed similar reductions in psychotic symptomatology from baseline to 2-year follow-up which were significantly larger than those observed with respect to the TAU group.

5-year follow-up data for this cohort was provided by Seikkula et al. (2006) who compared the ODAP-I and API groups, which in this paper consisted of 42 and 33 participants respectively; a disparity which is not accounted for by the authors. Significant differences were observed at 2-year follow-up whereby the ODAP-I group displayed fewer hospitalisation days, and lower psychotic symptomatology then the API

group. No significant differences were observed between groups at 5-year follow up, except for the ODAP-I group receiving more network meetings than the API group.

One paper describing 2-year follow-up outcomes for a second cohort associated with the *Open Dialogue in Acute Psychosis Project* who received treatment between 2003 and 2005 was identified (ODAP-II cohort; Seikkula et al., 2011). This paper compared outcomes for the ODAP-II group with the API and ODAP-I cohorts described above. Significant differences were observed between the groups such that the ODAP-II cohort displayed significantly fewer hospitalisation days than the API group, as well as a shorter duration of untreated psychosis, but higher Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) scores than the ODAP-I group. Significantly higher BPRS scores were also observed in the API group compared to those in the ODAP-I group.

Two papers identified in the search provided outcome data relating to individuals who received treatment as a member of one of each of the three API, ODAP-I, and ODAP-II above (Bergström et al., 2017, 2018). Bergström et al. (2017) provided up to 23-year follow-up data on 65 such individuals (OD-3 group) and examined long term use of psychiatric services. The majority of participants had between 0 and 1 hospital admissions with participants who displayed physical aggression at the outset more likely to be hospitalised, and those who were hospitalised quickly displaying more hospital re-admissions and a longer duration of treatment than those who were not. Participants who displayed physical aggression at the outset also displayed a longer duration of treatment. And, those who commenced neuroleptic medication at the outset were found to have more hospital re-admissions and a longer duration of treatment than those that did not.

Bergström et al., (2018) compared the OD-3 group above with a control group of 1763 individuals representing all Finnish first episode psychosis cases whose treatment was delivered within a similar time frame outside of the Western Lapland region and thus not within the principles of OD. The follow-up period in this study was up to 19 years. The OD-3 group displayed significantly fewer hospital treatment days and hospital readmissions than the control group. Fewer OD-3 participants were still in contact with treatment services compared with the control group. Neuroleptic medication was used significantly less frequently in the OD-3 group than the control group. Significantly lower rates of disability allowance use were observed both during, and at the follow-up period in the OD-3 group compared to the control group.

In summary, papers describing studies involving Finnish cohorts presented outcome data relating to three main OD cohorts; WLP-OD, ODAP-I, and ODAP-II. Two papers additionally described outcomes relating to these three cohorts combined (OD-3 Cohort). Follow-up data points ranged from two to 23 years. Comparison groups included both TAU, and earlier iterations of OD with less emphasis on dialogism (e.g. API cohort). In general, papers reported positive outcomes for OD cohorts relative to comparison conditions on a range of outcomes in areas such as mental health status, service utilisation, neuroleptic mediation use, and psychosocial functioning.

Outcome studies: US cohort

One paper describing the outcomes of a small feasibility study which was conducted in the US was identified (Gordon et al., 2016). The project was conducted over 12 months in an attempt to apply OD principles to an already existing mobile crisis team in Massachusetts. A total of 14 individuals completed outcome measures at baseline, and 3, 6, and 12 months post-treatment. Clinical outcomes were generally positive, with

results of linear mixed-model analyses showing significant improvements in psychiatric symptomatology, psychosocial functioning, work/school participation, and number of hospital days, with improvements in decision making self-confidence approaching significance.

Qualitative service user and staff experiences studies

Three papers were identified which focussed on staff and service user experiences of the implementation of OD (Gordon et al., 2016; Holmesland et al., 2010; Piippo & Aaltonen, 2004). Gordon et al., (2016) undertook semi-structured interviews with staff and service users who had been involved in their US OD pilot project. Service users reported liking the less medicalised approach, as well as the feeling of openness and transparency within the approach, but highlighted the need for additional social work support within the service. Staff members reported that they enjoyed working within the principles of OD, that the approach made them feel better able to engage their clients, and promoted a sense of safety. Practical barriers to OD implementation were highlighted by some.

Holmesland et al., (2010) aimed to explore challenges to professional identity in multi-agency network meetings, with a particular focus on how professional identity is related to the development of professional roles and transdisciplinarity in multi-agency network meetings. Results described how some professionals experienced difficulty in adapting their role to the OD way of working with anticipation of stereotypical roles by those unfamiliar with network meetings strongly affecting this process. Personality factors were also seen as important with regard to collaboration and role evolution, as social competence was perceived necessary for close collaboration and fostering a sense of

security and mutual reliance. 'Social and educational professionals' reported that they did not always feel accepted due to issues relating to power and hierarchy.

Finally, Piippo & Aaltonen (2004) examined service user experiences at an OD implementation in Sweden using semi-structured interviews. Participants reported several positive aspects of OD such as its social network perspective, the manner in which it facilitated several points of view being expressed, and its focus on co-operation rather than objectification. Participants however reported doubts about the sustainability of OD related changes, and worries regarding the feelings of other network members, as well as disliking when practitioners became overly enthusiastic about OD, or overly abstract in their language.

Qualitative therapeutic processes studies

Five papers were identified which described OD therapeutic processes (Lidbom et al., 2014, 2015; Piippo & Aaltonen, 2008; Seikkula, 2002). Seikkula (2002) analysed transcripts of network meetings in order to describe 'monological' and 'dialogical' dialogue in good and poor outcome cases; 'monological' here referring to instances where it appeared as though, in contrast to the dialogical approach, one voice or perspective was afforded primacy over those others present in the network meeting. Results revealed that when dialogical dialogue was reached themes stayed the same for longer which facilitated a deeper exploration of those topics when compared to monological dialogue. Good outcomes were also associated with families who appeared to take greater control of the topics, words used, and interaction patterns in network meetings. Symbolic language use, that is words about words, versus concrete language was also associated with good outcomes.

One paper focused on the manner in which trust is fostered within network meetings. Piippo and Aaltonen (2008) interviewed service users who had participated in their Swedish OD implementation finding that they reported that trust was fostered through honest reciprocal co-creation of knowledge in network meetings. Mistrust on the other hand was fostered when participants felt that they were being influenced too much or excluded by staff members.

Holmesland et al., (2014) examined practitioner perspectives on understandings of what promotes or impedes dialogue in inter-agency meetings, with a particular focus on how this is related to their professional backgrounds. Results described how participants emphasised the importance of creating a dialogical space where all participants felt listened to, and solutions not too hastily suggested. Self-disclosure was also seen as an important pre-requisite in building an atmosphere of authenticity and trust. The authors also report that those in the 'social and educational' professionals group appeared to be less experienced in framing their in-session emotional reactions in a manner which might promote dialogue when compared to their 'health worker' colleagues and this impacted on the promotion of dialogue in network meetings. However, it should be noted that the authors do not report on the disciplines represented in each of the two aforementioned groupings.

Finally, two papers focussed on the relationship between inner and outer dialogues in network meetings (Lidbom et al., 2014, 2015), both of which were conducted at the same Norwegian OD implementation using a bespoke data collection method where network meetings were first videotaped, key moments identified, and participants asked to watch those moments and report on their inner dialogue, that is the content of their internal speech, at that key moment. Results revealed that inner dialogues are an

important element of allowing participants to consider different perspectives, and to promote dialogic conversation in network meetings. When dialogue became monologic, participants tended to report withdrawing into inner dialogue and away from the therapeutic conversation.

Study quality assessment

Study quality analysis revealed a number of issues with regard to the OD outcome studies identified in the review. Looking to the results of QATQS assessment, the majority of ratings for the six key domains examined by the tool were rated as fair or poor. In general, outcome studies tended to be rated as good on data collection methods, using robust objective measures of outcomes as well as well-established psychometric measures which have demonstrated good reliability and validity. Participant selection was also a domain that tended to be rated as good as outcome studies were generally strong in recruiting participants appropriate to the research question. All other domains tended to be rated as fair or poor. Most studies were rated as poor in terms of design due to the fact that they were, on the whole, retrospective in nature and did not involve blinding or randomisation of participant group allocation. They also mostly involved the same Finnish cohorts limiting generalizability. And, most involved the key individuals involved in the development of OD leading to potential researcher allegiance bias; a trend which has been observed in which studies undertaken by model developers tend to produce better results than those carried out by independent researchers (Munder, Brütsch, Leonhart, Gerger, & Barth, 2013). Results of study quality assessment for qualitative papers were more positive. Global scores ranged from 7-10 out of a maximum score of 10, indicating that all studies were of good or very good quality. With regard to validity, 3 studies received a maximum score of 6, and 5 a score of 5. Four studies received a maximum score of 3 in the results domain, 2 received a score of

2, and 1 a score of 1. All studies were assessed as being potentially useful locally. Where studies were assessed less favourably, this was generally due to authors not fully describing the ethical aspects of the research design, or not fully acknowledging and/or exploring their own positions with regard to the research.

Discussion

A systematic review identified 15 papers in which primary research was undertaken to examine the OD approach to mental health care. These consisted of one dual study mixed methods paper and further 14 single study papers. Eight of the identified studies described OD outcomes and 8 described OD implementation and therapeutic processes. Results of outcome studies, which primarily involved individuals experiencing first episode psychosis, on the whole, revealed positive clinical outcomes on a number of key variables such as reductions in psychotic symptomatology and hospital admissions along with improvements on indices of social functioning. Results of the 8 implementation and therapeutic processes studies highlighted the importance of concepts such as transparency, openness, authenticity, and the elicitation of multiple perspectives in the successful delivery of OD and, in particular, the dialogic aspect of the approach. They also pointed toward a high degree of staff and service user acceptability. A number of concerns were also highlighted such as staff difficulties relating to working in a transdisciplinary manner, and service user concerns regarding the process of therapy meetings and the sustainability of OD related changes.

The results of the outcome studies identified compare favourably with those of studies involving other, more widely implemented approaches to the treatment of first episode psychosis for example Cognitive Behaviour Therapy (CBT) based approaches (Correll, Galling, Pawar, et al., 2018). The OD approach appears to be particularly strong with

regard to indices such as service utilisation, relapse prevention, and employment status. These positive outcomes must be tempered however by a consideration of the results of study quality appraisal which revealed an evidence base characterised by retrospective studies lacking in randomisation and blinding, involving small and often sub-optimal comparison groups, and mostly undertaken by the model developers at the original OD development location in Finland. In addition, no studies described any steps taken to ensure fidelity to the principles of the OD approach. These limitations speak to the evolving nature of the OD approach and consequent difficulties in comparing different implementations and cohorts involved in a principles-based model of service delivery where the potential for heterogeneity of treatment delivery practices and methods exists. It is difficult therefore to make any strong conclusions about the effectiveness of the OD approach based on the outcome papers identified in this review.

Results of study quality analysis for implementation and therapeutic processes studies were more favourable with the global quality of all studies being rated as 'good' or 'very good' suggesting that a good deal of confidence can be placed in their results. The emphasis on aspects of transparency, openness, authenticity, and the elicitation of multiple perspectives present in these studies along with the high degree of acceptability evident for those receiving treatment though the principles of OD supports previous research examining service user treatment preferences. Stovell (2016), for example, interviewed individuals with experience of treatment for psychosis within traditional modalities finding that these participants believed feeling listened to and supported in communicating their perspective, along with a valuing of different conceptions of recovery, and the provision of 'non-medicalised' options to be important components of acceptable treatment. Similarly, Byrne, Davies, and Morrison (2010) in a narrative review of service user perspectives on the helpful elements of treatment for psychosis

identified treatment preferences for person-centered, and collaborative approaches to care. The OD approach may thus represent a means through which these identified positive aspects of treatment may be delivered. Further, Suter et al. (2009) in a qualitative study of Canadian healthcare professionals working in transdisciplinary teams, found open communication to be a key component of successful collaborative work, thus the elements of transparency, openness, authenticity, and the elicitation of multiple perspectives may also be important in overcoming some of the difficulties for professionals in adapting to working within the principles of OD identified in some of the reviewed studies.

A number of methodological weaknesses to the present review must be acknowledged. First, by confining the search to published, peer-reviewed, English language papers it is possible that a number of important studies may have been excluded. This is particularly relevant given that the OD approach was first developed in Scandinavia where English is not spoken as a mother tongue (for a comprehensive review of Scandinavian OD studies see Buus et al., 2017). Second, assessment of study quality was conducted by the first author only and thus it is possible that this appraisal over or underestimated the quality of papers identified in the review. Nevertheless, a number of strengths can also be identified. First, to our knowledge, this paper represents the first attempt to review only OD studies in which primary research was undertaken. In doing so it represents a first attempt in assuage previous criticisms of the lack of focus on this type of research within the OD literature base (Torrey, 2011). Second, the paper also represents, to our knowledge, the first attempt to apply well established formal measures of study quality appraisal to identified OD literature. Finally, the search was conducted using both electronic and manual means by two independent researchers

increasing the level of confidence that can be placed in the study to have identified all relevant papers.

A number of avenues for future research can be identified. First, future reviews may be strengthened by including non-English language and grey literature studies. Second, this review has revealed a relative strength within the OD literature with regard to implementation and therapeutic processes studies compared to relatively weaker studies which aim to describe OD outcomes. It appears that staff and user experiences, as well as the key therapeutic ingredients of the OD approach have been well elucidated in the literature. However, high-quality outcome studies are lacking. The OD research agenda should therefore refocus toward the generation of high-quality evidence relating to therapeutic outcomes ideally in the form of randomised controlled trials in which robust outcome measures and fidelity checks are employed; a move which is currently underway in the UK in the form of the ODDESSI multi-centre trial (Pilling, 2018). Third, no studies were identified which examined the cost effectiveness of OD. Cost effectiveness is an increasingly important metric when considering health service delivery (van Baal, Morton, & Severens, 2018). Future research should examine this aspect of the delivery of treatment though the OD model of care. Finally, the majority of OD studies identified focussed on this approach as a treatment for first episode psychosis. Future studies should examine the applicability of the model to other mental health difficulties.

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Conflict of interests statement

The authors declare no conflict of interests.

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Appendix A: Systematic review protocol

A systematic review of Open Dialogue studies involving primary data collection.

Systematic Review Protocol Proposal

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Background

Open Dialogue (OD) is a family- and social network-based approach to the treatment of psychosis, and other serious mental health difficulties developed in Finland in the 1980's and 1990's (Seikkula, Alakare, & Aatonnen, 2001). The approach is based upon the seven core principles of immediate help, a social network perspective, flexibility and mobility, responsibility, tolerance of uncertainty and dialogism, (Olson, Seikkula, & Ziedonis, 2014; Seikkula et al., 2001). These are operationalised in a manner which seeks to maximise transparency and to place service users and their networks at the centre of their care. Less emphasis is placed on medication in favour of using a dialogic approach to psychotherapy to facilitate the generation of an individualised plan for recovery involving the referred individual and their personal support network.

A number of attempts have been made to describe the evidence base with regard to OD. Gromer (2012) for example, conducted a systematic review of outcome studies relating to OD and the Need Adapted Approach (NAA) concluding that there is good evidence to suggest these approaches are effective in reducing the frequency of relapses, hospital admissions, and the need for neuroleptic medication, as well as increasing indices of social functioning. Lakeman's (2014) narrative review attempted to examine the evidence for the effectiveness of the OD approach as well as to identify its critical ingredients, concluding that the literature pointed toward promising outcomes, but that more rigorous studies were needed both to establish the effectiveness of the approach and to discern whether it is the OD elements of treatment packages which are leading to positive outcomes. Finally, Buus et al.'s, (2017) review outlined the development of OD in Scandinavia finding the studies identified characterised by small sample sizes,

heterogeneity of implementation types, and poor fidelity checks. Nevertheless, the authors suggest that the identified literature described OD as a welcome alternative to conventional mental health service delivery and practices by professionals, service users, and their families. A number of difficulties were also highlighted however, such as resistance to implementation from practitioners in the context of role changes as a result of OD implementation, and some families reporting discomfort with the group format of network meetings.

The above reviews, while helpful, have a number of limitations such as having been conducted some time ago and thus not including more recent studies, failing to include a formal assessment of study quality using a robust assessment tool, or focussing on one location only and thus omitting studies from the full range of locations in which OD has been implemented to date. Further, previous reviews have tended to include papers such as discussion pieces and illustrative composite case studies in which no primary research was conducted, and this lack of focus on primary research has been criticised by some authors as a weakness with regard to the OD evidence base (Torrey, 2011). The aim of the present review is thus to provide a current and comprehensive review of OD studies which involved primary data collection.

Methods

Inclusion and exclusion criteria:

1. *Participants*

    Studies involving adults experiencing any mental health difficulty will be included in the review. Studies relating to OD practitioners will also be included.

2. *Interventions*

    Only papers relating to the OD approach will be included in the review. Papers will be deemed to fulfil this criteria by demonstrating the seven principles of OD as described by Seikkula et al. (2001). Papers describing studies relating to any other intervention, or where OD is offered in combination with another intervention will be excluded.

3. *Research design*

   Randomised and non-randomised prospective studies will be included in the review, as will prospective observational studies and studies employing case series designs. Due to the heterogeneous nature of the design of qualitative studies, all designs will be considered for inclusion. Only papers involving primary research will be included. Opinion/commentary pieces and review papers will be excluded.

4. *Outcome measures*

   As this review concerns itself with implementation, outcome and process studies, it is likely that a range of outcome measures will be evident in the literature. Thus, papers will not be excluded on the basis of outcome measure.

5. *Settings*

   Papers will not be explicitly excluded on the basis of study setting or geographic location. Nevertheless as the review will include papers written in English only, it is possible that studies from non-English speaking nations may not be captured.

6. *Outlets*

   Only papers from peer-reviewed English language journals will be included in the review.

Search strategy:

1. *Electronic searches*

   Electronic searches will be carried out by DH using Psycinfo, Science Direct, and PubMed using the following search terms: "open dialogue approach or open dialogue or open dialogue therapy or open-dialogue approach or open-dialogue or open-dialogue therapy". As OD was first developed in the 1980s the electronic search will be restricted to 1980 onwards as papers published before this year are likely to be irrelevant. Results will be initially screened for duplication of papers across different databases. Where duplicates are found they will be removed. The remaining list of potentially eligible studies will be screened by DH on the basis of their title and abstract and irrelevant studies

excluded. Full-text copies of remaining potentially eligible papers will used to assess them for possible inclusion/exclusion.

2. *Reference harvesting*

Reference lists of previous review papers and relevant articles will be examined in order to identify potentially eligible papers.

3. *Grey literature*

As this paper is concerned with peer-reviewed papers grey literature will not be searched.

Data collection

1. *Study selection*

Studies identified for inclusion in the review by DH as described above will additionally be independently assessed on the basis of this protocol by another researcher. Percentage agreement will be reported and differences resolved by consensus. Where agreement is not possible a third researcher will be invited to make a final decision on inclusion.

2. *Data extraction*

Data extraction will be conducted independently by both DH and another researcher. Percentage agreement will be reported and differences resolved by consensus. Where agreement is not possible a third researcher will be invited to make a final decision on inclusion. Following guidance provided in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2011), quantitative studies to be included in the review will be coded on the basis of their participants, intervention, comparison groups, and outcomes. A similar but modified approach based on guidance provided by Buttler, Hall, & Copnell (2016) will be used to code the characteristics of qualitative studies to be included.

3. *Risk of bias/study quality assessment*

Risk of bias/study quality assessment will be independently conducted by DH and another researcher. Percentage agreement will be reported and differences resolved by consensus. Where agreement is not possible a third researcher will

be invited to make a final decision on inclusion. With regard to quantitative studies, risk of bias will be assessed using guidance outlined in Section 8 of the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2011). With respect to qualitative studies paper quality will be assessed following guidance provided by Buttler et al. (2016).

Analysis

1. *Study stratification*

   Qualitative and quantitative studies will be analysed separately. PRISMA guidelines for the reporting of meta-analyses (Moher, Liberati, Tetzlaff, Altman, & Group, 2009) will be followed throughout.

2. *Quantitative studies*

   In the event that a sufficient number of papers are identified, and methodological homogeneity permits, the results of quantitative studies will be pooled using meta-analytic techniques described by Borenstein, Hedges, Higgins, and Rothstein (2009). Risk of publication bias will similarly be conducted under these circumstances. Where insufficient numbers of papers are identified, or where significant methodological heterogeneity exists, the results of included papers will be described in tabular and narrative format only. The decision as to the method of analysis will be made by DH in collaboration with another researcher.

3. *Qualitative studies*

   In the event that a sufficient quantity of qualitative papers are located, results will be synthesised following guidelines described by Buttler et al. (2016). Where insufficient papers are located the results of included papers will be described in tabular and narrative format only. The decision as to the method of analysis will be made by DH in collaboration with another researcher.

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Seikkula, J., Alakare, B., & Aatonnen, J. (2001). Open Dialogue in psychosis I: An introduction and case illustration. *Journal of Constructivist Psychology*, *14*, 247–265.

Appendix B: Author guidelines for Study 1 target journal

Author guidelines for the Early Intervention in Psychiatry

Submission

Thank you for your interest in *Early Intervention in Psychiatry*. Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

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Early Intervention in Psychiatry publishes original research articles and reviews dealing with the early recognition, diagnosis and treatment across the full range of mental and substance use disorders, as well as the underlying epidemiological, biological, psychological and social mechanisms that influence the onset and early course of these disorders. The journal provides comprehensive coverage of early intervention for the full range of psychiatric disorders and mental health problems, including schizophrenia and other psychoses, mood and anxiety disorders, substance use disorders, eating

disorders and personality disorders. Papers in any of the following fields are considered: diagnostic issues, psychopathology, clinical epidemiology, biological mechanisms, treatments and other forms of intervention, clinical trials, health services and economic research and mental health policy. Special features are also published, including hypotheses, controversies and snapshots of innovative service models.

In contrast with mainstream healthcare, early diagnosis and intervention has come late to the field of psychiatry. *Early Intervention in Psychiatry* creates a common forum for researchers and clinicians with an interest in the early phases of a wide range of disorders to share ideas, experience and data. This journal not only fills a gap, but also creates a new frontier in academic and clinical psychiatry.

Manuscript categories and requirements

Articles reporting original work that embodies scientific excellence in psychiatry and advances in clinical research (maximum word count for text 3000; abstract 250);

Reviews which synthesize important information on a topic of general interest to early intervention in psychiatry. (maximum word count for text 5000; abstract 250);

Brief Reports which present original research that makes a single point, or negative studies of important topics (maximum word count for text 1500; abstract 150);

Early Intervention in the Real World, a special features section which focuses on issues such as service descriptions and delivery, and clinical practice guidelines (maximum word count for text 3000; abstract 250);

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Trade names. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name, and the name and location of the manufacturer, in parentheses.

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*The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

*Abstract and keywords;

*Main text;

*Acknowledgements;

*Conflict of interest statement;

*References;

*Tables (each table complete with title and footnotes);

*Figure legends;

*Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

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Please refer to the journal's authorship policy the Editorial Policies and Ethical Considerations section for details on eligibility for author listing.

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Five key words, for the purposes of indexing, should be supplied below the abstract, in alphabetical order, and should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **http://www.nlm.nih.gov/mesh/meshhome.html**.

Text

Authors should use the following subheadings to divide the sections of their manuscript: Introduction, Methods, Results and Discussion.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial

and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

References

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one, and a DOI should be provided for all references where available.

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi:10.1176/appi.ajp.159.3.483

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

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• Final approval of the version to be published; AND
• Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

In addition to being accountable for the parts of the work he or she has done, an author should be able to identify which co-authors are responsible for specific other parts of the work. In addition, authors should have confidence in the integrity of the contributions of their co-authors. All those designated as authors should meet all four criteria for authorship, and all who meet the four criteria should be identified as authors.

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Study 2: Practitioner perspectives on Trauma Informed care and the Open Dialogue approach to mental health care.

Title: Practitioner perspectives on Trauma Informed care and the Open Dialogue approach to mental health care.

Authors: Dan Hartnett[1,2], Maria Dempsey[1], Iseult Twamley[2]

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Word count: 6919 (excluding abstract, figures, tables, and references)

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Keywords: Open Dialogue, Trauma Informed Care, Trauma.

Prepared in accordance with author guidelines for The International Journal of Mental Health Systems (See Appendix J). Tables and figures are presented in text for ease of examination.

Abstract

Background: In a perspective which has come to be termed Trauma Informed Care (TIC), there is growing recognition that services in which traumatised individuals may be involved should be organised and delivered in a manner which is sensitive to what is known about trauma. Despite tentative conceptual links between the Open Dialogue (OD) approach to mental health care and TIC as well as moves toward implementing TIC awareness in clinician training, little is known about how OD practitioners understand the concept of TIC, or how this understanding, if at all, impacts their work. The aim of the present study was thus to explore OD practitioner perspectives on TIC and OD. **Methods:** Fourteen OD practitioners across seven countries and six mental health disciplines completed online demographic and service profile questionnaires and participated in semi-structured interviews. Data were analysed using Thematic Analysis. **Results:** Six key themes were evident in the data; understanding trauma informed care, on the client's terms, stories not symptoms, using reflections, continuity and consistency, and barriers to dialogism. These represented participants' understanding of TIC, as well as a number of perceived trauma-sensitive OD elements. Challenges to implementing these trauma sensitive aspects were also highlighted and these appeared most relevant with regard to the interface between network meetings and the wider health and social services system. **Conclusions:** OD may exhibit some TIC congruent elements, and the fact that clients are free to construe their experiences as trauma related or not, may represent an avenue for client empowerment which is less present in traditional more 'trauma assumptive' TIC models. As in other TIC implementations, a whole-systems approach may be needed to fully implement these TIC aligned OD aspects. The associated shift in organisational structures, particularly the non-hierarchical approach advocated in OD may pose a particular barrier to implementation outside of the Finnish context.

Background

There is good evidence to suggest that traumatic experiences are both prevalent and associated with a host of negative outcomes for those who experience them. A large scale retrospective study of over 17,000 participants conducted in the United States, for example, found that over half of those surveyed endorsed having experienced at least one adverse childhood experience such as psychological, physical or sexual abuse, living in household involving domestic violence, or with individuals experiencing mental health or substance misuse difficulties, or a history of imprisonment (1). A number of subsequent studies have examined the impact of childhood trauma exposure on physical health outcomes finding that those with trauma histories are more likely than those in the general population to develop a host of ailments such as cardiac and lung disease, diabetes, and arthritic disorders amongst others (2). Other studies have focused specifically on mental health difficulties demonstrating a link between early trauma exposure and the development of problems such as depression (3), anxiety (4), and psychosis (5). as well as increased risk for suicide and self-harm (6). Further, the effects of exposure to trauma exposure appear to be cumulative with some studies suggesting that early trauma exposure is a risk factor for further exposure to traumatic events in later life, and that the greater the number of exposures the greater the negative effects observed (1,7–10).

Given these findings it is not surprising that research suggests that individuals who access mental health services are more likely to have experienced traumatic events than the general population. A systematic review, for example, found prevalence rates of 47% and 37% for physical and sexual abuse respectively for individuals experiencing severe mental health difficulties, compared to rates of 21% and 23% in the general population (11). Moreover, a survey of three hundred randomly recruited psychiatric

patients in the United Kingdom found that 27% of female participants had experienced domestic violence in the past year compared to 9% in the general population, with 10% of men reporting this experience compared to 2% in the general population (12). These results are supported by a recent meta-analysis which found that individuals experiencing mental health difficulties were between two and 22 times more likely to have experienced physical, sexual, and domestic violence in the last year (13).

A number of authors have argued that a high portion of individuals accessing mental health services experience traumatic events as a result of their involvement with those services (14,15). These experiences include acts of overt violence such as physical or sexual assaults by other service users (16). They also include traumatic events related to systemic issues such as policies and practices which fail to provide a treatment environment that feels safe. Service users most frequently report as traumatic, coercive acts such as enforced medication compliance, restraint, and seclusion, as well as the use of stigmatising language, and the minimisation of past trauma by staff (17,18). Re-traumatisation refers to the process of being traumatised again when a present experience is reminiscent of a past traumatic event which triggers the same emotional and psychological responses associated with the original event (19). There is evidence to suggest that those with a trauma history more frequently report negative treatment events, and experience a higher level of resultant subjective distress than those who have not previously experienced trauma (20). A key feature of this re-traumatisation process, it has been argued, is the exercise of power and control over service users which is reminiscent of past experiences of powerlessness experienced during previous traumatic events (19). Indeed, due to the neurological effects of trauma, survivors may be predisposed to respond to experiences of loss of power, choice, control and safety in ways that may appear extreme or abnormal when their previous exposure to adverse

events is not taken into account (21).

Over the last number of years, in recognition of the prevalence and pervasive effects of trauma, a perspective, termed Trauma Informed Care (TIC) has emerged. TIC seeks to embed this understanding of trauma into the organisational fabric f services in which individuals with trauma histories are potentially involved (22,23). TIC is distinct from the provision of trauma specific services in that rather than specifically attempting to resolve trauma sequela, the approach instead aims to foster an emphasis on trauma sensitivity in all service activities (24); sensitivity that extends, for example, to a view of presenting difficulties as efforts to cope in the face of adverse experiences rather than symptoms of psychopathology (23). The United States Substance Abuse and Mental Health Services guidelines on TIC (SAMHSA; 25) suggest that an organisation is trauma informed if it realises the widespread impact of trauma and understands potential paths for recovery, recognises the signs and symptoms of trauma in clients, families staff and others involved in the system, and responds by integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation. TIC is underpinned by a number of key principles which seek to promote activities congruent with the creation of physical and psychological safety, the maximisation of trustworthiness and transparency, and the equalisation of power dynamics between service users and staff. TIC also seeks to empower service users to express choices in terms of their path to healing and staff to facilitate those choices. An awareness of cultural, historical and gender issues, and access to peer support is also emphasised (25,26). Thus, TIC seeks to avoid inadvertently repeating the dynamics of abuse interactions in helping relationships but instead to foster the opposite conditions of traumatic experiences (27).

Developed in Finland in the 1980's and 1990's, Open Dialogue (OD) is a whole-system family- and social network-based approach to the treatment of psychosis, and other serious mental health difficulties which has been noted alongside TIC by authors advocating for alternative, less medicalised systems of service delivery (28,29). The approach has been successfully implemented in a number of sites in both Scandinavia and internationally, and there is emerging evidence to suggest that it is effective in reducing the frequency of relapses, hospital admissions, and the need for neuroleptic medication, as well as increasing indices of social functioning (30,31). OD espouses the seven core principles of immediate help, a social network perspective, flexibility, mobility, responsibility, tolerance of uncertainty, and dialogism, which are operationalised in a manner to maximise transparency and to place service users and their networks at the centre of the treatment process (32,33). The core unit of treatment is the network meeting, which ideally occurs as soon as possible following referral and involves both the referred individual and their identified support network, with the same team members accompanying the referred individual throughout their treatment journey. The purpose of the network meeting is to gather information about the problem, to build a treatment plan, and to generate psychotherapeutic dialogue (34). This focus on dialogue aims to support those involved in developing a shared language through which they can make sense of their experiences and move forward (35). It involves elements such as giving equal weight to each voice in the network meeting, and using open ended questions to facilitate the exploration of the history and perceived meaning in relation to presenting difficulties (36). Individuals participating in network meetings are also exposed to the team's 'reflections' whereby co-therapists turn to each other and discuss their thoughts, feelings, and impressions about what a network has spoken about, including potential options for treatment, and then invite those present to respond to what they have heard if they wish (35). OD thus involves two key aspects; first, network

meetings in which all relevant network members participate from the outset to generate new understandings through dialogue, and second a set of guiding principles for structural aspects of the entire system of psychiatric practice (37,38).

As the TIC perspective has grown, a number of attempts have been made to explore the manner in which its guiding principles might manifest in a range of treatment settings such as services involved with individuals experiencing homelessness (39), substance misuse difficulties (40), and serious mental health difficulties (41,42). With respect to OD, Wallner and Klapcinski (43), noted a high number of individuals presenting to Polish mental health services with trauma histories and proposed that the approach may be an appropriate means through which to meet their needs in a more trauma informed way. Moreover, TIC specific training has in recent years been included in OD training programmes (44). Nevertheless, some have argued that there continues to be some ambiguity surrounding how TIC principles are understood and implemented in everyday practice (45). Very little research exists with regard to the manner in which practitioners construe the concept of TIC or how these principles affect their everyday work. Regarding OD, despite the aforementioned tentative conceptual links and moves toward implementing TIC awareness in clinician training, to our knowledge, no studies have examined how practitioners understand the concept of TIC, or how this understanding, if at all, impacts their work. The aim of the present study was thus to explore OD practitioner perspectives on TIC and OD.

Methods

Design and procedure

The study used a primarily qualitative design involving semi-structured interviews along with a minor quantitative component in which online survey instruments were

used to profile participants and the services in which they were working. The study was nested within an essentialist/realist epistemological paradigm. As an exploratory study involving two emerging paradigms, a bottom-up, "inductive" approach to data analysis was used. In this way, the themes identified were strongly linked to the data rather than being driven by any pre-conceived theoretical framework (46). In keeping with the essentialist/realist position of the research frame however, in analysing the dataset experience and meanings were theorised in a straightforward way with a largely unidirectional relationship assumed between meaning, experience and language (46). Following from this epistemological position, and in contrast to more constructionist approaches, latent themes were thus not considered nor were the ways in which broader societal discourses may impact upon participant realities, meanings and experiences (46,47). The themes reported thus reflect patterned responses within the dataset representing an assumed reality reported by participants (46).

Institutional ethical approval was obtained (See Appendix C). Participants were recruited via notices placed on OD related social media outlets and circulated via relevant email lists. Inclusion criteria were: being over 18, having successfully undertaken a one-year foundation training in OD or higher and currently practicing in mental healthcare within the principles of OD. No specific exclusion criteria were applied however all data was collected through English which may have excluded those not proficient in that language. Two steps were involved in participation. In step one, via an online survey platform, participants provided informed consent to participate in the study and completed a demographic and service profiling questionnaire (See Appendices D, E, and F). Step two involved the participation in a semi-structured interview guided by an interview schedule which was flexibly applied in order to probe for participants thoughts on TIC as well as their views with respect to key areas of

inquiry based on SAMHSA key principles of TIC (25; See Appendix G). Interviews were conducted by the first author between September 2018 and February 2019, and were between 40 and 60 minutes in duration. One interview was conducted with a participant in person with the remainder conducted via telephone or online videoconferencing software.

The interview process was one which evolved as the study progressed. Initial interviews were based more closely on the specific questions and structure of the interview protocol than later interviews. For example, following the second interview, instead of beginning with an exploration of the TIC key principle of 'safety', participants were instead invited to describe their own understanding of TIC as well as to discuss perceived linkages between OD and that understanding, the manner in which those linkages are operationalised in real world practice, and the barriers to the implementation of those identified perceived TIC congruent OD elements. If and when, during this discussion, participants touched on key principles of TIC they were asked to expand on those areas. If at the end of the discussion they had not touched on a particular TIC key principle, they were invited to discuss their views on that key principle in relation to OD. This flexible approach was taken to allow for a broader and richer understanding of participant perspectives and thus mitigate an identified risk of imposing an artificial TIC frame onto their responses.

Participant characteristics

Fourteen OD practitioners participated in the study, six male and eight female ranging in age from 32 to 60 years (M=49.36; SD=7.73). Table 1 below presents details of participant disciplines and locations. Two participants were located in Germany, three in the United Kingdom, one in Italy, one in Ireland, two in Finland, one in the Netherlands,

and three in Australia. Disciplines sampled included two Psychologists, three Psychiatrists, one Occupational Therapist, three Social Workers, three Peer Workers, and two Psychotherapists. Eleven worked in the public health system, two in private services, and one in the voluntary sector. Participants had been practicing within the principles of OD between one and 15 years (M=4.07; SD=3.45), with 10 spending in excess of 50% of their clinical time working in this modality, and the remaining four allocating between 10% and 40% to OD specific work (M=65.36; SD=43.50). Eight participants had received advanced training in OD, two intermediate level training, and four foundation level training. Three participants reported having a trauma specific qualification, while three had attended short courses on the topic, the remainder had no specific trauma related training outside of that received during basic discipline specific training. Participants reported working on teams ranging in size from two to 60 members (M=13; SD=14.96), with between 2 and 60 of those team members OD trained.

Table 1: Participant locations and disciplines.

Location	Psychol.	Psychi.	OT	Discipline SW	PW	PT	Total
Germany					1	1	2
United Kingdom	1			1	1	1	4
Italy		1					1
Ireland			1				1
Finland	1	1					2
Netherlands				1			1
Australia		1		2			3
Total	2	2	1	4	2	2	14

Note: Psychol.=Psychology, Psychi.=Psychiatry, OT=Occupational Therapy, SW=Social Work, PW=Peer Worker, PT=Psychotherapy.

Data analysis.

Interview recordings were transcribed verbatim by the first author. Data were analysed using an approach to Thematic Analysis modelled on Braun and Clarke's guidelines

(46). As suggested by these authors this involved a six step process. The first step of the analysis process involved a familiarisation with the data. As all interviews were conducted and transcribed verbatim by the first author this facilitated a good general sense of interview contents. In addition, this familiarisation was supported though discussion between the authors both at regular research meetings as the project progressed and before the initial coding process.

Next, transcripts were organised into meaning units; the smallest units of data which could stand alone while still conveying a clear meaning (48). The core ideas (49) represented in this data were then extracted and applied as codes to these meaning units. At this initial coding stage, as suggested by Archibald (50), all authors reviewed a number of pages of initial codes together then coded a further section independently before reviewing together. This ensured a robust analytical process and enabled the research team to attend to issues of investigator triangulation and management of researcher bias.

In the third step of the analysis process, the focus moved from the level of coding to the broader level of themes across the dataset. Following discussion between the authors, recurring codes were grouped together to form a preliminary thematic map (See appendix H).

Fourthly, the aforementioned preliminary map was further refined to produce a final thematic map. This process involved taking time, in discussion between the authors, to further group and refine the many possibilities in order to come to a final map which succinctly yet comprehensively captured the essence of the data. This task involved an iterative process of going back to the data and checking and rechecking its cohesiveness

two levels: within and across themes. That is, firstly codes and meaning units constituting each potential theme were re-examined to ensure that they formed robust patterns which cohered meaningfully while at the same time being distinct from one another. Secondly, patterns across themes were examined in order to form a final thematic map. As described by Grbich (51), this step of analysis involved a process of reorganising, merging, and dropping initially identified themes, and then checking back with the data to ensure that the themes contained in the final thematic map constituted a meaningful representation of the data. For example, in the final thematic map elements of the preliminary theme 'embodiment of dialogical space' were merged with 'slow pace; allowing time and space' to form the final theme 'spacing and pacing'.

The fifth step of the process was to make final refinements to theme names and definitions. This again involved a discussion between all authors. A number of considerations were made in this regard, for example the theme of 'continuity and consistency' was originally called 'the same team throughout', but was renamed following discussion between the authors as it was felt, when the constituent data was again consulted, that this final theme name captured the essence of the content in a more elegant manner.

Finally, in order to present a clear, coherent, and evidenced account of the data, time was devoted to ascertaining the best order in which to present the identified themes in the final paper, as well as the best illustrative quotations to use.

Position of the authors.

The adoption of a reflexive approach to the research process is now widely accepted as a key aspect of working with qualitative data. For example, a number of authors have

highlighted the fact that the interpretation of this type of data, is in some respects, a process in which meanings are made rather than found (52,53). Bracketing refers to the use of techniques such as journaling and memo writing in order to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research, thereby increasing the rigor of the project (54). While this process may have been helpful with regard to the present study by elucidating some of the biases with which the researchers came to the project, nevertheless some authors have described inherit problems in attempting to "uncover" biases in this way such as the limitations of researcher self-awareness at any given time (54,55). Indeed there is evidence to suggest that some biases may exist on an implicit basis making them difficult to be brought into conscious awareness (56). With this in mind, following Ortlipp (57), rather than attempting to control researcher characteristics which might impact the research process through bracketing or method, a decision was instead made to simply describe these characteristics at the outset. We therefore feel it important to acknowledge the fact that all authors came to the project with a history of previous interest and involvement with OD; the first author having a previous interest in OD, and been on clinical placement at an OD implementation site for portion of time overlapping with the data collection period, and the second and third authors as having a history of longstanding involvement with OD training, practice and research. Of note however, a conscious decision was made to take an inductive approach to data analysis in which themes were driven by the data collected rather than deductively derived from frameworks based on TIC or OD principles, and this may serve to some degree as a counterbalance to these potential biases. Nevertheless we wish to explicitly acknowledge this aspect of this work (see Appendix H).

Results

Thematic analysis revealed six key, sometimes overlapping, themes present in the data (see Table 2). Descriptions of these themes along with illustrative quotations are presented below.

Table 2. Key themes and sub-themes where relevant.

1. Understanding Trauma Informed Care.

2. On the client's terms.
    2.1 An open start.
    2.2 Spacing and pacing.
    2.3 Facilitating choices.
    2.4 A 'not knowing' stance.

3. Stories not symptoms.
    3.1 'What's happened not what's wrong'.
    3.2 Seeking to understand.

4. Using reflections.
    4.1 Take it or leave it.
    4.2 Slow things down.

5. Continuity and consistency.

6. Barriers to dialogism.
    6.1 A wider system.
    6.2 Risk.
    6.3 Hierarchies.

Theme 1: Understanding trauma informed care.

While some participants alluded to understanding TIC as being related to a system wide approach to trauma sensitivity, the majority spoke of TIC as a simple recognition that a good number of individuals presenting to services may have histories of adverse experiences and that this should be taken into account in the manner in which clinicians interface with those individuals:

"I think many of the people we see, probably the majority of the people we see, have experienced some sort of trauma in their lives and we have to take that into account in the interactions that we have with them"

<div align="right">(Participant 14)</div>

Relatedly, there was also a sense that, for most participants, TIC involved understanding the difficulties experienced by individuals attending services as being related to past adverse events, and that problematic symptoms and behaviours may be seen as meaningful when thought of in light of previous traumatic experiences:

> "I think it [TIC] says the experience of young people with unusual experiences or experiencing psychiatric crisis often come in with a history of trauma and that their experience is a way of trying to resolve some of those difficult experiences in the past or currently"

<div align="right">(Participant 12)</div>

This understanding of TIC appeared to be largely based on clinical experience and previous training rather than knowledge of formal frameworks or principles. Few participants spoke of having an awareness of these knowledge bases but instead spoke of a trauma awareness present in their everyday work based on that clinical experience and previous training:

> "… my understanding of Trauma Informed Care…it's very clinically based and it's based on all on my work with children and young people and adults who've had a significant experience of trauma and neglect."

<div align="right">(Participant 11)</div>

"I feel that trauma informs every aspect of my work...but it's never been, it wouldn't be used in the sense of those three words Trauma Informed Care...I don't use it as a term."

<div align="right">(Participant 3)</div>

Theme 2: On the client's terms.

The theme of *on the client's terms* represents practitioners descriptions of the emphasis which they viewed OD places on the maximisation of client choice both in terms of the process and content of their engagement with the service. This emphasis was, in general, described as maximising choice and thus leading to an important sense of safety and control when working with those affected by traumatic life events. A number of participants highlighted the fact that within this approach the attending service user sets the agenda for each session and this was seen as leading to *an open start* which lessens the likelihood of individuals being forced to speak about traumatic events before they are ready to do so:

"...what we do is to not have kind of initial interviews of clients. We prefer to have...quite open questions...not to specifically start having interviews about the life history or so called symptoms...the emphasis is on talking about what people want to talk about...aware of ideas of...possibility to re-traumatise when you kind of make people talk about the issues they don't want to talk about"

<div align="right">(Participant 10)</div>

Spacing and pacing of sessions was also seen as a trauma sensitive aspect of the OD approach. Participants spoke of taking a slow approach to the therapeutic process and

allowing space for clients to discuss traumatic events, if present, in their own time. In addition, clinicians described efforts to create a safe and non-pressurised environment by respecting the client's pace of change and tolerating the difficult emotions which often accompany traumatic material:

"...when there's trauma, you need time for that person...to find the words. And that might not be quick...It might be [the] second, third, fourth session...we can't force people to talk about their trauma. All you can do is create a space where they might be able to find the words or explore their feelings. But you can't force it."

(Participant 4)

Facilitating choices in terms of practical aspects of the therapeutic process such as the composition, location, timing, and duration of network meetings was also discussed by a number of participants. This was viewed by some as a means through which a sense of control and safety might be fostered which was seen as important for those presenting with trauma histories:

"...we can talk about the...content issues, but also to think together about how we should proceed, and who should meet whom, and what do they feel is comfortable."

(Participant 10)

"...for somebody who's been traumatised, they've been traumatised by a position of powerlessness, so how can that person feel that they have control of when the meetings happen, where the meetings happen?...having some people

not in the room...that choice is really critical; that they feel in charge of who's present...and that we don't presume to know who should be in the room but they determine that."

Several participants spoke of adopting a *'not knowing stance'* whereby assumptions in relation to what might be helpful for clients were actively avoided by clinicians. This appeared to be viewed by practitioners as a key aspect of supporting service users in taking control of their path through treatment:

"...it's that idea of we just don't know [what might be helpful]...because people's stories are so complex, and have been going on for a long time, and involve so many nuances, and everything is so individual...[it's important] to be curious about what people's ideas of their own needs are, their own ways forward"

In addition, a number of participants spoke of making efforts to position their professional knowledge as just one of a number of different viewpoints in order to maximise client choice. A core component of this appeared to be placing an emphasis on multiple possible truths existing within the network meeting, and the use of tentative language:

"I might...draw from my own experiences or from professional ideas, but I don't consider them being really kind of truths...I want to bring them openly under the scrutiny of other people...So it's really that 'I got this thought, but I'm not sure

what you're thinking about these thoughts'".

<div align="right">(Participant 10)</div>

Theme 3: Stories not symptoms.

The theme of *stories not symptoms* represented the view, which all participants expressed, of the strong emphasis placed on personal narrative and meaning making within OD. A key aspect in this respect appeared to be a view of presenting difficulties in terms of *'What's happened not what's wrong'*. That is, practitioners overwhelmingly described an OD congruent view of the difficulties with which clients come to services as one which conceptualises these as understandable responses in the context of past events:

> "For me the big difference [between OD and TAU]...is the non-pathologising of the individuals response to trauma. It's not some deficit or something wrong with the person. It's a human response to something in their life. And so we're really trying to move it away from something is wrong with them and more into something that happened to them"

<div align="right">(Participant 12)</div>

In terms of drawing out these narratives and meanings, practitioners discussed taking time and making great efforts in facilitating network members in *seeking to understand* the nature and history of presenting difficulties from multiple perspectives; making efforts to elicit multiple view points and to generate dialogue rather than solutions. Participants also spoke of postponing treatment decisions until a full understanding of the context within which an individual's difficulties have developed is established:

"Your responsibility is to provide dialogue and to put every voices (sic) and thoughts on the table. So you're not responsible for solutions. That's big shift."

<div align="right">(Participant 9)</div>

"You might go on to think about what's going to be helpful in terms of treatment, but that comes some way down the line...[following] those initial sessions of really truly understanding what has happened to this person, what has happened to them in the context of their network, their family."

<div align="right">(Participant 4)</div>

One participant noted that, in their view, OD is in a sense 'trauma-neutral' in this regard in that service users are free to construe their experiences in whatever way feels most comfortable to them:

"I suspect a trauma-informed approach...would have some sort of a theoretical understanding of how people behave…as being specifically related to trauma...whereas the dialogical approach...tries not to cross that bridge about assuming why people...behave in a certain way...So the dialogical practitioner would talk about allowing a narrative of trauma to unfold if that's how the person chooses to see it."

<div align="right">(Participant 8)</div>

Theme 4: Using reflections.

Many participants spoke of *using reflections* as an aspect of OD with particular relevance in relation to sensitivity to the potential presence of prior traumatic life events. A number of participants, for example, mentioned reflections as a means to equalise power dynamics between practitioners and network members, and to allow for greater choice in relation to material discussed. The indirect nature of reflections, whereby difficult material can be discussed between clinicians instead of directly with the client, was seen as taking pressure off clients to respond to therapist utterances, and thus a way for clinicians to tentatively introduce topics while at the same time allowing network members the choice to *take it or leave it*:

> "….all the clients have said that the reflection is the key thing that's amazing because it stops the power inequality...It's a conversation that you're actually having with another colleague…the client's an observer to that, so they're not under any direct pressure...they're able to observe and process what's actually being spoken about in front of them…then it's their choice…if they want to then add to that dialogue"

(Participant 13)

Reflections were also spoken of in terms of a way of modulating the high emotion that often accompanies discussion of traumatic material. Again, the indirect nature of reflective discussion was emphasised here with several practitioners describing this process as a means of taking the focus off clients for a period; assisting them to regulate their emotions and to *slow things down* in session:

"It gives them [the network] a break. And if I think about when I do reflections,

it's when...anxiety starting to rise, when there's any form of emotion as well, in the

family or a member of the family, it's a way of marking that without, again,

without sort of coming face to face with it, which, yeah, seems to be incredibly

helpful."

(Participant 11)

"It takes away an intensity…sometimes [when] people are sharing traumatic

experiences there's an intensity in the room, and sometimes taking a reflection to

give people time to just breathe and hear what we've heard, what we felt, and that

can be really helpful. It kind of slows things down."

(Participant 4)

Theme 5: Continuity and consistency.

A small number of practitioners spoke of their view of the OD principle of

'psychological continuity' and the fact that where possible a client is met by the same

team throughout their treatment journey. These participants emphasised the fact that

they viewed this principle as a means of promoting *continuity and consistency* and

fostering a sense of safety and trust in the therapeutic relationship. With particular

relevance to individuals with trauma histories, one participant discussed the fact that

ensuring continuity in the treatment team means that traumatic material does not have to

be retold to multiple individuals in different contexts; an experience which they felt can

be distressing:

"I think what it does [psychological continuity] is help to avoid or at least to

reduce having people with trauma histories, or any person who is seeking help,

to not have to retell their story to lots of different people in a way. That can be

confusing, it can be upsetting, and it can mean they don't feel heard or

understood."

(Participant 12)

Most participants who mentioned this principle also acknowledged however that it is

not always possible to ensure a consistent treatment team for the duration of an

individual's involvement with a service. This appeared to be particularly relevant in

cases where OD was offered as part of a wider human services system not necessarily

operating within the principles of the approach, with one participant noting difficulties

in transporting the Finnish model to other locations:

"...it's not always possible in a complex social health services system like ours

which might interface with lots of different parts of our service like in-patient

services or other community services so it's not as integrated as we would like."

(Participant 12)

"...within OD teams, you're not supposed to change the members of the team.

But the way that it's set up, the members of the team kept on changing...So even

though we're all doing OD, it's not OD Open Dialogue...because they're not set

up like the team in Finland".

(Participant 13)

Theme 6: Barriers to dialogism.

The theme of *barriers to dialogism* represented practitioner's discussions of ways in

which the generation of therapeutic dialogue and the aforementioned efforts to place

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control in the hands of clients regarding the content and process of their path through services can be hampered. As alluded to above, several participants spoke of these barriers in terms of OD operating within *a wider system*. Some participants spoke of the fact that while they believed OD to be trauma sensitive, the same was not necessarily true for other associated organisations operating alongside their OD implementation:

> "...our service is in other services. One of the very great difficulties is where, as a clinician...we are very intent on not re-traumatising the people we work with, but the organisations above us aren't quite so bothered by that"
>
> (Participant 11)

Risk was identified as a particular factor in terms of these systems taking control of the treatment process. Some participants discussed the fact that the medico-legal responsibilities of professionals in relation to ensuring appropriate management of risk made it more difficult for them to provide an open space for discussion, and more likely for systems outside of the network meeting to take control of the decision making process:

> "The stronger the amount of worry in the system around safety. When extreme behaviour is difficult to manage; to do with expressions around ideas of hurting self or hurting others that can really push systems into taking over."
>
> (Participant 12)

Decision making *hierarchies* both within and outside of the network meeting also appeared to be sometimes problematic. Some participants again spoke of these

pressures as being particularly relevant in the interface between OD and other non-OD aligned services such as in-patient treatment facilities. In addition, in-session power dynamics between co-therapists in terms of professional hierarchies were relevant for a number of practitioners whereby some therapists felt it difficult to share their views or disagree with more senior colleagues which also appeared to act as a barrier to dialogism:

> "I was working with a member of staff, he was a lot more senior than me, and he didn't want to stay. When you're in a network meeting, you're supposed to be there until the end of whatever's being said. You're not supposed to put an agenda in, but he was putting an agenda in because he had another client to actually right go and see."

(Participant 13)

Discussion

The aim of the present study was to explore OD practitioner perspectives on TIC and OD. As such, a number of pertinent points have been raised. Given that OD predates much of the modern literature on trauma and TIC, and that very little has been written from the dialogic perspective in these specific areas, it is unsurprising that few practitioners mentioned an awareness of, or made links to, such literature. Nevertheless, participants did highlight a number of practices which appear, at least to some degree, compatible with articulations of the TIC perspective (21,24) such as an awareness of the potential presence of adverse life experiences for clients, and the central emphasis placed on narrative and meaning making in the OD approach in which presenting difficulties are seen as logical consequences of life events. In addition, the slow pace of the therapeutic process and the fact that clients set the agenda for each session were

described as OD elements which have the effect of minimising the likelihood of re-traumatisation as they allow service users to discuss traumatic material on their own terms. Similarly, participants spoke of the facilitation of choices in terms of the location, timing, and composition of network meetings as aspects of their practice which foster a sense of control and safety both of which are aspects of TIC best practice principles (25). The equalisation of power dynamics between service users and staff is also advocated in the TIC literature (21,25,26), and clinicians described practices which appear congruent with this aim, such as taking a 'not knowing stance' in relation to what might be helpful for clients, using tentative language, positioning their professional knowledge as just one of a number of possible truths, and using 'reflections' to allow clients to make a choice as to whether to respond to the ideas discussed therein. Finally, participants highlighted the fact that the number of times traumatic material must be re-told in different contexts is minimised due to continuity in the treatment team and this minimisation of trauma re-telling is also advocated in the TIC literature (21). Thus, a number of perceived areas of potential congruence between OD and TIC frameworks can be identified.

Indeed, it is noteworthy that a number of these perceived areas of potential congruence represented in the identified themes above map closely onto OD principles. As noted previously, the theme of *continuity and consistency* may be considered to speak to the reported effect of the principle of *psychological continuity* in reducing the likelihood that those presenting with trauma histories are required to retell their story in multiple contexts. Similarly, the theme of *stories not symptoms* and the sentiment expressed therein of delaying treatment decisions until a full understanding of an individual's presenting difficulties is developed may be considered to espouse a similar ethos to the OD principle of t*oleration of uncertainty*. Finally, the sub -themes of *take it or leave it*

and *a not knowing stance*, may speak to elements of the OD principle of *dialogism*, which provides for an equalisation of all voices within the network meeting in order that a shared understanding of an individual's difficulties be developed. It may be then, that these OD principles may represent key elements with regard to meeting those presenting with trauma histories in a more sensitive way.

Nevertheless, notwithstanding these areas of concordance, a number of areas of departure can also be identified. A key aspect of the dialogical stance is the positioning of knowledge frameworks in a manner which can be accepted or rejected by clients, and which represent just one of a number of possible truths, with the client free to construe their own narrative in whatever way feels most comfortable for them (58). While some have noted that a misconception surrounding TIC is that the approach construes all psychological difficulties as arising from traumatic experiences (59), many TIC implementation guidelines continue to afford a primacy to trauma-based explanations of presenting difficulties, and of routinely screening for the presence of trauma (60). It is noteworthy therefore, that one participant explicitly described OD as being in a sense 'trauma-neutral' regarding the manner in which meaning making of previous life events is facilitated; clients being free to construe their experiences in whatever way they wish, trauma related or not. In addition, it appeared from the data that while practitioners remained aware of the potential presence of adverse life events, at the same time they took great lengths to ensure client control over disclosure of traumatic material if present. Both of these positions appear to differ from TIC frameworks in that they place less emphasis on trauma as an explanatory factor with regard to presenting difficulties, and do not advocate for the routine assessment for the presence of traumatic life events. OD may thus represent an approach which is 'trauma-sensitive' but less 'trauma - assumptive' than traditional TIC implementation frameworks. Moreover, a critique of

some more explicitly trauma-informed frameworks has been that this 'trauma-assumptive' position may act to disempower service users in a similar manner other more traditional approaches some of which advocate, for example, a bio-medical understanding of difficulties, by imposing a similarly extrinsic account of service user experiences (61). The apparently 'trauma-sensitive' but 'trauma-neutral' position adopted within the OD approach may thus represent an avenue for service user empowerment as it appears to seek to maximise client control with respect to disclosure and meaning making.

Systemic challenges were also highlighted by some participants. Importantly in this respect, the majority of clinicians sampled in the present study were located in services where OD operates within a wider health and social services system not necessarily aligned with the principles of the approach. This organisational set-up is in contrast to the Finnish context in which the entire psychiatric system is organised in line with OD principles. With regard to the implementation of explicitly trauma informed approaches, many have emphasised the need for a whole-systems approach to organisational change (19,24). Indeed there is some evidence to suggest that agency factors such as whole-system buy-in are more important than individual staff characteristics with regard to the successful implementation of TIC initiatives (62). In the present study, some participants alluded to a perception that they themselves along with many aspects of network meetings were trauma sensitive, but that this was not necessarily the case in the wider system of services. Thus, it appears as though OD is subject to similar implementation challenges to be found with respect to more explicitly trauma-informed models of care. In addition, some participants highlighted implementation issues related to professional and decision making hierarchies. The non-hierarchical approach advocated in the OD approach represents a significant departure from traditional models

of care potentially requiring a substantial organisational shift for those involved. The ever changing nature of health service offerings has been highlighted by some as a potential barrier to implementing TIC in the public health service (19) and thus it may be that the implementation of OD is also subject to these challenges.

A number of limitations and caveats must be highlighted with respect to the present study. First, participants interviewed represented a self-selecting sample and thus may have come to the study with a pre-existing interest in trauma and trauma-informed care. It cannot be ruled out therefore that other, less trauma-sensitive perspectives were not represented. Second, participants were recruited across a broad range of contexts. This was consistent with the aim of the study as an exploratory investigation. Nevertheless, this recruitment strategy poses challenges with regard to the depth of information gathered. An investigation involving more participants, or focussing on less implementation sites may have facilitated a more nuanced view of the issues raised. Third, the present study assessed for practitioner perspectives only and as such does not give voice to the experiences of those attending services. It is possible that clients experience OD services differently from how practitioners perceive them to experience them. The fact that the study concerned itself with practitioner perspectives additionally means that it should not be construed as a formal assessment of OD-TIC congruency, but rather one which presents clinicians views of their work. It may be that there are differences in how clinicians view their practices and how these actually manifest in reality. Finally, the majority of TIC literature to date has pertained to services operating in the United States (US). While OD has been implemented in that location, in the present study none of the participants sampled were located in the US and therefore these perspectives were not represented.

Notwithstanding these limitations, in line with best practice guidelines for the publication of qualitative research (63), several factors point toward the trustworthiness of the results presented as being a reliable and authentic reflection of the subject matter in question. First, the authors have outlined their own roles within the project as well as explicitly attending to their previous involvement in OD. Second, the sample in question has been adequately situated through a description of participants' demographic information as well as the services within which they operate. Third, the results of the study have been grounded in examples with at least one illustrative quote provided per theme. Fourth, issues of researcher bias have been considered though well established and rigorous methodology the details of which are transparently outlined in the paper. Finally, an adequate number of participants across a wide enough set of instances were recruited to facilitate the stated aim of the paper as seeking to provide a general exploration of the subject matter.

A number of avenues for future research can be identified. As mentioned above, the present study has involved practitioners only. It would be worthwhile to extend participant sample to investigate the views of other stakeholders including service users, particularly those presenting with trauma histories. Further, as the present study concerned itself primarily with practitioners outside of the Finnish context, and implementation issues were highlighted with regard to the transportation of the Finnish model to other locations, a comparative study involving practitioners from both within and outside of Finland may be helpful in elucidating these issues. Finally, formal assessment tools of TIC principle alignment are available (64,65) and it would be worthwhile to use these tools to obtain a more objective measure of OD-TIC congruency.

Conclusions

The present study represents, to our knowledge, the first investigation of practitioner perspectives on OD and TIC. While participants, on the whole, did not display a knowledge of formal TIC literature, they nevertheless described a number of apparently TIC congruent OD practices. These concordances were particularly relevant with regard to aspects of network meetings, and the apparently 'trauma-sensitive' but 'trauma-neutral' position adopted within the OD approach may represent an avenue for service user empowerment as it appears to seek to maximise client control with respect to disclosure and meaning making in a manner that departs from traditional TIC models of care. The results of this study also point to the fact that network meetings do not happen in a vacuum however, as participants also highlighted a number of barriers to implementing these TIC aligned components which appear similar to challenges found in other explicitly TIC aligned models of care. The need for a whole-systems approach to TIC implementation has been highlighted in the literature, and it may be that the associated shift in organisational structures, particularly the non-hierarchical approach advocated in OD poses a particular barrier to its implementation outside of the Finnish context. Further research will be required to elucidate these issues.

Abbreviations

TIC: Trauma Informed Care; SAMHSA: Substance Abuse and Mental Health Services Administration; OD: Open Dialogue; M: Mean; SD: Standard deviation; Psychol.: Psychologist; Psychi.: Psychiatrist; OT: Occupational Therapist; SW: Social Worker; PW: Peer Worker; PT: Psychotherapist; US: United States.

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Appendix C: Ethical approval

Revised Ethics Application

1 message

Hennessy, Nora <NHennessy@ucc.ie>   Mon, Apr 23, 2018 at 2:06 PM
To: "116222823@umail.ucc.ie" <116222823@umail.ucc.ie>
Cc: "Murphy, Mike (Applied Psychology)" <Mike.Murphy@ucc.ie>

Dear Dan,

Thank you for your revised Ethics application. The committee has reviewed this and are happy for you to proceed, however you should review the following with your supervisors:

- Recruitment especially to part 2 remains vague. I don't think this is "snowball sampling". Sample representativeness / homogeneity remains a quality issue.
- The information sheet still looks a bit leading – it essentially says TIC is good practice and this research is checking how far OD practitioners adhere to these principles.

Kind Regards,

Nora

Nora Hennessy | Programme Administrator, DCLIN Psychology| School of Applied Psychology| Enterprise Centre North Mall Campus |UCC |Ph: (021) 4904512

Appendix D: Information and consent forms

Exploring Trauma-Informed Care and the Open Dialogue Approach to Mental Health Care

Thank you for taking the time to read this information. My name is Dr Dan Hartnett. I am a Doctoral Candidate in Clinical Psychology at the School of Applied Psychology, University College Cork, Ireland. I am conducting this project under the supervision of Dr Iseult Twamley, Senior Psychologist and Open Dialogue Clinical Lead, West Cork Mental Health Services, and Dr Maria Dempsey, Lecturer, School of Applied Psychology, University College Cork.

What is the purpose of the study?

In a perspective which has come to be termed Trauma Informed Care (TIC), there is growing recognition that there is a need to integrate our knowledge of trauma into the organisational fabric of services operating in this area (Mihelicova et al., 2017). That is, as well as offering trauma-specific services, the organisations which deliver those services should themselves be organised and delivered in a manner which is sensitive to what is known about trauma. While some efforts have been made to explore TIC in different treatment contexts little is know about how TIC might apply to OD. This study aims to explore OD practitioner attitudes and perspectives on TIC as it applies, if at all, to their work.

Who can participate?

We are aiming to sample a range of clinicians from the global community of OD practitioners. We would ideally like to involve at least one practitioner from each OD implementation group worldwide.

You can participate if:

- Over 18 years of age.

- Have received 1 year equivalent training in OD (Foundation Course).

- Currently practicing in mental health care within OD principles (for at least some of your clinical work).

While we have no specific exclusion criteria, it is important to note that assessment instruments and interviews will be administered and conducted in English.

What is involved in participation?

Participation involves completing two questionnaires and a semi-structured interview.

Questionnaires:

The questionnaires will be completed via an online form and will take about 15 minutes to complete. They will ask you about:

Demographic information about you and your service.

Your attitudes toward TIC.

Semi-structured interview:

The semi-structured interview will be conducted by Dr Dan Hartnett via telephone/skype at a time which is convenient to you. The interview will last about 50 minutes, will be audio recorded, and will ask about your views on TIC and OD. Once the interview has been transcribed the audio recording will be deleted.

What are the benefits of participating?

This study will give you the opportunity to voice your opinions and experiences of working through the Open Dialogue model, and of TIC. Your participation will help us to understand more about the model and TIC which will add to the research base in this area.

Do I have to participate?

Participation in this study is entirely voluntary. You may withdraw from the study at any time and have your data removed up to two weeks post-interview by contacting me via the details provided below.

Are there any risks to participating?

There are no known risks associated with this study. You will be able to withdraw your participation at any time, up to the point at which you submit your responses. Support will be available from the research team should you request it.

How will my data be stored and used?

Your data will be stored on a secure server, in anonymised format, in password protected files by the research team at UCC for 10 years. The data we collect may be published in scholarly journals and presented locally and nationally but <u>no individual participant</u> will be identified.

Where can I get further information about the study?

If you would like to know more about the study you can contact the research team via the details below:

Dr Dan Hartnett, School of Applied Psychology, University College Cork,
Email: dan.hartnett@umail.ucc.ie.

Dr Maria Dempsey, School of Applied Psychology, University College Cork,
Email: m.dempsey@ucc.ie

Dr Iseult Twamley, Centre for Mental Health Care & Recovery, Bantry General Hospital.
Email: iseult.twamley@hse.ie

INFORMED CONSENT FORM

Exploring Trauma-Informed Care and the Open Dialogue Approach to Mental Health Care

Please tick the boxes below to indicate your agreement with the following statements:

I am currently practicing within the principles of open dialogue.

Yes [ ]   No [ ]

I have received at least one year equivalent of training in Open Dialogue

Yes [ ]   No [ ]

I have read and understood the Participant Information Sheet and agree to the conditions of the study and use of data outlined therein.

I agree [ ]   I do NOT agree [ ]

I agree to and give consent to take part in this study.

I agree [ ]   I do NOT agree [ ]

I understand that I can withdraw from the study and have my data removed from the study up to two weeks post-interview by contacting Dan Hartnett at daniel.hartnett@umail.ucc.ie.

I agree [ ]   I do NOT agree [ ]

Typing your name and clicking submit will serve as your digital signature.

Name _____

Appendix E: Online assessment instruments

Exploring Trauma Informed Care and the Open Dialogue Approach to Mental Health Care	
Demographic and Service Profiling Questionnaire	
1. What is your name?	
2. What is your job title?	
3. What is the name of the organisation you work for?	
4. What is your email address?	
5. What is your telephone number?	
6. What is your gender?	Female
	Male
	Other
	Prefer not to say
7. What age are you now?	Age: Prefer not to say
8. What is your first language?	
9. In what country are you practicing within the principles of Open Dialogue?	
10. In what discipline (if any) are you trained?	Psychology Psychiatry Nursing Occupational Therapy Social Work Peer Worker Other (please state):
11. What is the highest level of Open Dialogue training you have received?	
12. How long have you been practicing within the principles of Open Dialogue?	

13. In what type of organisation do you work?	Public health service. Voluntary organisation. Private service. Peer led organisation Other (Please state):
14. Do you work within a team?	
(If yes to Q8) 15. How many team members are Open Dialogue trained?	
(If yes to Q8) 16. Which disciplines are represented on your team?	Psychology Psychiatry Nursing Occupational Therapy Social Work Peer Worker Other (please state):
(If yes to Q8) 17. How long has your team been offering services within the principles of Open Dialogue?	
18. What percentage of your clinical work do you undertake within the principles of Open Dialogue?	
19. Have you ever received trauma specific training?	Yes No (if yes): please provide details.

Note: Although this measure formed part of the online assessment protocol, results relating to it were not reported due to issues with respect to their meaningful interpretation, such as the absence of a comparator group or population norms.

ARTIC

Attitudes Related to Trauma-Informed Care Scale
VERSION: ARTIC-45 HUMAN SERVICES

TRAUMATIC STRESS INSTITUTE

People who work in human services, health care, education, and related fields have a wide variety of beliefs about their clients, their jobs, and themselves. The term "client" is interchangeable with "student," "person," "resident," "patient," or other terms to describe the person being served in a particular setting.

Trauma-informed care is an approach to engaging people with trauma histories in human services, education, and related fields that recognizes and acknowledges the impact of trauma on their lives.

INSTRUCTIONS

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

Sample

	1	2	3	4	5	6	7	
Ice cream is delicious	○	●	○	○	○	○	○	Ice cream is disgusting.

Note: In this SAMPLE ITEM, the respondent is reporting that he/she believes that ice cream is much more delicious than disgusting.

I believe that…

		1	2	3	4	5	6	7	
1	Clients' learning and behavior problems are rooted in their behavioral or mental health condition.	○	○	○	○	○	○	○	Clients' learning and behavior problems are rooted in their history of difficult life events.
2	Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○	○	○	○	○	○	○	Rules and consequences are the best approach when working with people with trauma histories.
3	Being very upset is normal for many of the clients I serve.	○	○	○	○	○	○	○	It reflects badly on me if my clients are very upset.
4	I don't have what it takes to help my clients.	○	○	○	○	○	○	○	I have what it takes to help my clients.
5	It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○	○	○	○	○	○	○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.
6	The clients were raised this way, so there's not much I can do about it now.	○	○	○	○	○	○	○	The clients were raised this way, so they don't yet know how to do what I'm asking them to do.
7	Clients need to experience real life consequences in order to function in the real world.	○	○	○	○	○	○	○	Clients need to experience healing relationships in order to function in the real world.
8	If clients say or do disrespectful things to me, it makes me look like a fool in front of others.	○	○	○	○	○	○	○	If clients say or do disrespectful things to me, it doesn't reflect badly on me.
9	I have the skills to help my clients.	○	○	○	○	○	○	○	I do not have the skills to help my clients.
10	The best way to deal with feeling burnt out at work is to seek support.	○	○	○	○	○	○	○	The best way to deal with feeling burnt out at work is not to dwell on it and it will pass.
11	Many clients just don't want to change or learn.	○	○	○	○	○	○	○	All clients want to change or learn.

CONTINUED →

1

I believe that…

1	2	3	4	5	6	7

#	Left statement	Response	Right statement
30	How I am doing personally is unrelated to whether I can help my clients.	○ ○ ○ ○ ○ ○ ○	I have to take care of myself personally in order to take care of my clients.
31	If things aren't going well, it is because the clients are not doing what they need to do.	○ ○ ○ ○ ○ ○ ○	If things aren't going well, it is because I need to shift what I'm doing.
32	I am most effective as a helper when I focus on a client's strengths.	○ ○ ○ ○ ○ ○ ○	I am most effective as a helper when I focus on a client's problem behaviors.
33	Being upset doesn't mean that clients will hurt others.	○ ○ ○ ○ ○ ○ ○	If I don't control clients' behavior, other clients will get hurt.
34	If I told my colleagues how hard my job is, they would support me.	○ ○ ○ ○ ○ ○ ○	If I told my colleagues how hard my job is, they would think I wasn't cut out for the job.
35	When I feel myself "taking my work home," it's best to bring it up with my colleagues and/or supervisor(s).	○ ○ ○ ○ ○ ○ ○	When I feel myself "taking my work home," it's best to keep it to myself.

👁 *Note: Some of the following items pertain to people working at organizations that have ALREADY implemented trauma-informed care to some degree. If you do NOT work at such an organization, use the "N/A" option for any items that are not applicable to you.*

I believe that…

1	2	3	4	5	6	7	N/A

#	Left statement	Response	Right statement
36	Clients react positively to the trauma-informed care approach.	○ ○ ○ ○ ○ ○ ○ ○	Clients react negatively to the trauma-informed care approach.
37	I do not have enough support to implement trauma-informed care.	○ ○ ○ ○ ○ ○ ○ ○	I have enough support to implement trauma-informed care.
38	The trauma-informed care approach takes too much time.	○ ○ ○ ○ ○ ○ ○ ○	The trauma-informed care approach saves time in the long run.
39	When I feel like I can't handle this alone, I can go to my colleagues and/or supervisor(s) for help.	○ ○ ○ ○ ○ ○ ○ ○	There is not much support from my colleagues and/or supervisor(s) for my work.
40	The trauma-informed care approach is effective.	○ ○ ○ ○ ○ ○ ○ ○	The trauma-informed care approach is not effective.
41	I have the support I need to work in a trauma-informed way.	○ ○ ○ ○ ○ ○ ○ ○	The program talks about trauma-informed care, but it is really business as usual.
42	I am able to carry out all my responsibilities with respect to the trauma-informed care approach.	○ ○ ○ ○ ○ ○ ○ ○	I am not able to carry out all my responsibilities with respect to the trauma-informed care approach.
43	There is not much support from the administration for my work.	○ ○ ○ ○ ○ ○ ○ ○	There is clear indication that the administration supports my work.
44	I cannot manage all that the trauma-informed care approach requires.	○ ○ ○ ○ ○ ○ ○ ○	I can manage all that the trauma-informed care approach requires.
45	Everyone is committed to working in a trauma-informed way long term.	○ ○ ○ ○ ○ ○ ○ ○	This emphasis on working in a trauma-informed way is just a passing phase.

Thank you for your participation.

3

I believe that…

#		1	2	3	4	5	6	7	
30	How I am doing personally is unrelated to whether I can help my clients.	○	○	○	○	○	○	○	I have to take care of myself personally in order to take care of my clients.
31	If things aren't going well, it is because the clients are not doing what they need to do.	○	○	○	○	○	○	○	If things aren't going well, it is because I need to shift what I'm doing.
32	I am most effective as a helper when I focus on a client's strengths.	○	○	○	○	○	○	○	I am most effective as a helper when I focus on a client's problem behaviors.
33	Being upset doesn't mean that clients will hurt others.	○	○	○	○	○	○	○	If I don't control clients' behavior, other clients will get hurt.
34	If I told my colleagues how hard my job is, they would support me.	○	○	○	○	○	○	○	If I told my colleagues how hard my job is, they would think I wasn't cut out for the job.
35	When I feel myself "taking my work home," it's best to bring it up with my colleagues and/or supervisor(s).	○	○	○	○	○	○	○	When I feel myself "taking my work home," it's best to keep it to myself.

👁 **Note:** *Some of the following items pertain to people working at organizations that have ALREADY implemented trauma-informed care to some degree. If you do NOT work at such an organization, use the "N/A" option for any items that are not applicable to you.*

I believe that…

#		1	2	3	4	5	6	7	N/A	
36	Clients react positively to the trauma-informed care approach.	○	○	○	○	○	○	○	○	Clients react negatively to the trauma-informed care approach.
37	I do not have enough support to implement trauma-informed care.	○	○	○	○	○	○	○	○	I have enough support to implement trauma-informed care.
38	The trauma-informed care approach takes too much time.	○	○	○	○	○	○	○	○	The trauma-informed care approach saves time in the long run.
39	When I feel like I can't handle this alone, I can go to my colleagues and/or supervisor(s) for help.	○	○	○	○	○	○	○	○	There is not much support from my colleagues and/or supervisor(s) for my work.
40	The trauma-informed care approach is effective.	○	○	○	○	○	○	○	○	The trauma-informed care approach is not effective.
41	I have the support I need to work in a trauma-informed way.	○	○	○	○	○	○	○	○	The program talks about trauma-informed care, but it is really business as usual.
42	I am able to carry out all my responsibilities with respect to the trauma-informed care approach.	○	○	○	○	○	○	○	○	I am not able to carry out all my responsibilities with respect to the trauma-informed care approach.
43	There is not much support from the administration for my work.	○	○	○	○	○	○	○	○	There is clear indication that the administration supports my work.
44	I cannot manage all that the trauma-informed care approach requires.	○	○	○	○	○	○	○	○	I can manage all that the trauma-informed care approach requires.
45	Everyone is committed to working in a trauma-informed way long term.	○	○	○	○	○	○	○	○	This emphasis on working in a trauma-informed way is just a passing phase.

Thank you for your participation.

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Appendix F: Online debriefing statement

Exploring Trauma Informed Care and the Open Dialogue Approach to Mental Health Care

Debriefing Statement.

Many thanks for participating in our research. Dan Hartnett will be in contact you soon to arrange a semi-structured interview at a time which is convenient to you via the details which you provided. Interviews will be conducted by telephone/skype, will last approximately one hour, and will be audio recorded.

If you would like further information on the study or have been affected in any way by your participation you may contact the research team via the contact details below.

Dr Dan Hartnett, School of Applied Psychology, University College Cork,
Email: daniel.hartnett@umail.ucc.ie.

Dr Maria Dempsey, School of Applied Psychology, University College Cork,
Email: m.dempsey@ucc.ie

Dr Iseult Twamley, Centre for Mental Health Care & Recovery, Bantry General Hospital.
Email: iseult.twamley@hse.ie.

Appendix G: Interview schedule

Exploring Trauma Informed Care and the Open Dialogue Approach to Mental Health Care

Interview Protocol

The aim of this study is to advance understanding of TIC and OD from the perspective of OD practitioners. The data collection process will include semi structured interviews each of which will have three sections: introduction, interview and conclusion:

Part 1: Introduction

The researcher will introduce themselves in the context of being a Doctoral Candidate in Clinical Psychology at UCC and their particular interest in this area of research. Participants will be welcomed and thanked for agreeing to meet with the researcher. They will be reminded that they were provided with an information sheet and consent form, and that they provided consent to participate in advance of the interview via Qualtrics forms. Participants will be asked if there is any more information that they require and if they are happy to proceed.

Part 2: Interview

Each interview will begin with a statement of interest from the researcher in hearing about their experience of trauma informed care as it relates to practicing within the principles of OD. This will be followed by a suggested starting point i.e. *Can you tell me a little about your role within the service in which you operate?* From here it is expected that the researcher will draw on the interview anchor points, which will be refined in a flexible way to enable participants to describe and consider their perspectives on TIC and OD more fully.

Interview anchor points

The main anchor points of the interview will centre on:

1. In what ways do the principles of OD inform/support/challenge your understand safety in the context of your clinical work?

i. physical safety - safety of physical setting.

ii. psychological safety - safety of interpersonal interactions.

iii. difference between OD and application of generic therapeutic skills.

iv. barriers to maintaining safety.

2. In what ways do the principles of OD inform/support/challenge your understanding of transparency and trust in your work with clients and networks in the clinic room?

3. In what ways do the principles of OD inform/support/challenge your understanding of transparency and trust on an organisational level?

4. How do the principles of OD inform/support/challenge collaboration and power sharing at your service?

Prompts

i. Staff-client collaboration and power sharing.

ii. Power sharing and collaboration across all members of staff.

5. One of the best practice principles of TIC involves the empowerment of both staff and clients, to enable them to have a voice, and to actively express choices. In what ways do you think the principles of OD as practiced at your service support/inform/challenge this principle?

6. How do the principles of OD inform/support/challenge the ways your service is, if at all, sensitive to cultural, historical, and gender issues?

7. Can you say a little about how working within the principles of OD supports or does not support service user involvement in your service, if at all?

Part 3: Conclusion

At the end of the interview the researcher will ask the participants if they have any questions they would like to ask, comments they would like to make or if there was

anything in the interview that they would like to elaborate further on. The researcher will also ask how the participant is feeling and what the experience of the interview was like for them. Participants will be thanked for their participation in the study and reminded that if when reflecting on the interview they have any questions or comments they can contact the researcher or their supervisor. If they have any unease at the end of the interview process they will be guided to seek support from family, friends, or colleagues as appropriate.

Appendix H: Extended method section

The genesis of the project.

The concept for this project arose from a number of conversations I had with several individuals in the run up to submitting a formal project proposal for this thesis. Speaking to individuals from within the OD community about the approach there was a view expressed by some that there may be some hitherto unexplored trauma sensitive aspects of the approach. Taking this concept further, some made conceptual links between OD and formal TIC literature. These linkages seemed quite intuitive to me at the time. Nevertheless, in speaking with individuals outside of the OD community a view was expressed that these linkages may not be as intuitive as they may appear to others, and additionally, when I sought to explore the literature base in this regard I found that very little had been written on this subjects. At the same time, I was aware, of both OD and TIC frameworks having been named in writings advocating for novel ways of conceptualising mental health difficulties and delivering mental health services, and thus I became curious about where overlap between both approaches might exist and how this might inform future development of mental health services as well as my own practice going forward. I thus felt that I had identified a suitable, useful, and interesting topic of investigation both in terms of addressing a logical gap in the literature, and of making a possibly useful contribution to the advancement of clinical practice.

The position of the authors.

As noted in the main paper above, the adoption of a reflexive approach to the research process is now widely accepted as a key aspect of working with qualitative data. For example, a number of authors have highlighted the fact that the interpretation of this type of data, is in some respects, a process in which meanings are made rather than found (Mauthner & Doucet, 2003; Mauthner, Parry, & Backett-Milburn, 1998). With this in mind, it has been suggested that rather than attempting to control researcher characteristics which might impact the research process through bracketing or method, these should instead be consciously acknowledged and made explicit (Ortlipp, 2008). We therefore feel it important to acknowledge the fact that all authors came to the project with a history of previous interest and involvement with OD; the first author having a previous interest in OD, and been on clinical placement at an OD implementation site for portion of time overlapping with the data collection period, and the second and third authors as having a history of longstanding involvement with OD

training, practice and research. Of note however, a conscious decision was made to take an inductive approach to data analysis in which themes were driven by the data collected rather than deductively derived from frameworks based on TIC or OD principles, and this may serve to some degree as a counterbalance to these potential biases. Nevertheless we wish to explicitly acknowledge this aspect of this work.

The interview process.

Semi-structured interviews were guided by an interview schedule which was flexibly applied in order to probe for participants thoughts on TIC as well as their views with respect to key areas of inquiry based on SAMHSA key principles of TIC. Interviews were conducted by the first author between September 2018 and February 2019, and were between 40 and 60 minutes in duration. One interview was conducted with a participant in person with the remainder conducted remotely via telephone or internet. This interview process was one which evolved as the study progressed. Initial interviews were based more closely on the specific questions and structure of the interview protocol than later interviews. While the interview protocol was based on TIC principles, I soon found that interviewee perspectives were more nuanced than I might have expected. I also found that the interview schedule as originally designed imposed a somewhat artificial frame which limited the expression of practitioner responses. While TIC principles were still enquired about within each interview, taking a more flexible approach, and exploring themes mentioned by clinicians as they arose, allowed for a much richer exploration of practitioners perspectives which provided a deeper and broader understanding of their views.

The data analysis process

Interview recordings were transcribed verbatim by the first author. Data were analysed using an approach to thematic analysis modelled on Braun and Clarke's (2006) six step guidelines. Commentary on each step is provided below.

Data analysis step 1: Familiarisation with the data.

The first step of the analysis process involved a familiarisation with the data. As all interviews were conducted and transcribed verbatim by the first author this facilitated a good general sense of interview contents. In addition, this familiarisation was supported though discussion between the authors both at regular research meetings as the project

progressed and before the initial coding process.

Data analysis step 2: Generating initial codes.

Interviews were then organised into 'meaning units'; the smallest units of data which could stand alone while still conveying a clear meaning (Rennie, 1998). The 'core ideas' represented in this data were then extracted and applied as codes to those meaning units (Hill, Thompson, & Williams, 1997). At this initial coding stage, as suggested by Archibald (2015), all authors reviewed a number of pages of initial codes together then coded a further section independently before reviewing together. This ensured a robust analytical process and enabled the research team to attend to issues of investigator triangulation and management of researcher bias. Examples of this process are presented in table H1 below.

Table H1. Quotations, initial codes and focused codes illustrating the initial transcript coding process.

Quotation	Initial code	Focused code
But I think probably differs to a lot from other modalities where there's quite a set idea from the practitioners position about what's going to be helpful or how we're going to run the treatment or we need to get to or what we think are important issues.	OD differs from other modalities where practitioner determines treatment plan.	OD different; client determines treatment plan.
...and just, you know, really making the big decisions collaboratively, you know, is really important for power like 'Do you want to come back? When do you want to come back? Who needs to be here?' You know, lots of priority; is it seeing, is it meeting the doctors, talk about your medication or is it talking to your GP about, you know, whatever, and the person making the decision and who's best to have around for that discussion around medication.	Putting the power in the hands of the client to make decisions around issues like when to come back, who to have at the meeting.	Client makes decisions around time location who will attend etc.

I think it's the focus on dialogue instead of solutions. I think that's really powerful, because it makes that responding is first and reacting not.	Focusing on dialogue instead of solutions leads to responding rather than reacting.	Dialogue rather than solutions, responding rather than reacting.

Data analysis step 3: searching for themes.

The focus of the analysis at this point moved from the level of coding to the broader level of themes across the dataset. Following discussion between the authors, recurring codes were grouped together to form a preliminary thematic map. Braun and Clarke (2006) suggest that at this point it is important to identify all potential themes irrespective or their relevance to the research question or the amount of data though which they are constituted. This approach thus produced a large preliminary thematic map with many themes and sub-themes as can be seen in Figure H1 below. Examples of constituent codes for a sample of preliminary themes are also provided in table H2.
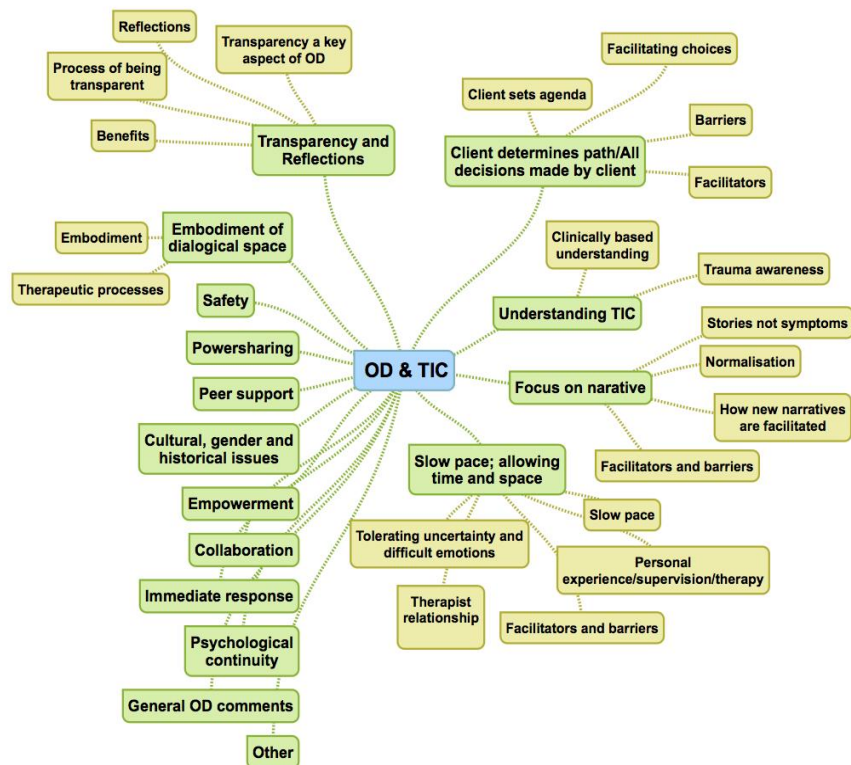

Figure H1: Preliminary thematic map

Table H2: Preliminary themes and example constituent codes.

Preliminary theme name	Example constituent codes
Client determines path/all decisions made by client: Client sets agenda.	Agenda set by client: Not necessary to talk about trauma unless client wants to.
	Client free to determine own path.
	Client has 'free reign' over therapeutic encounter.
	No interviews avoids forcing clients to speak about difficult material.
	Disclosure on client's terms avoids re-traumatisation.
Focus on narrative: Stories not symptoms.	OD: what's happened rather than what's wrong.
	OD seeks to understand experiences of individual and network .
	OD: from disease centred model of distress to focus on experiences.
	Seeking to understand, not provide solutions.
	Allowing trauma narrative to emerge naturally.
Transparency and reflections: Reflections.	Reflections: allow tentative introduction of topics.
	Power equalised through reflections; choice as to what to respond to.
	Reflections give opportunity to decide on whether to continue with topic
	Reflections: allow tentative introduction of topics.
	Reflections allow person to take it or leave it.

Data analysis step 4: Reviewing themes and forming the final thematic map.

The formation of the final thematic map was one of the most challenging aspects of the analysis process. Following Braun and Clarke (2006), this process involved taking time, in discussion between the authors, to further group and refine the many possibilities in order to come to a final map which succinctly yet comprehensively captured the essence of the data. This task involved an iterative process of going back to the data and checking and rechecking its cohesiveness two levels: within and across themes. That is, firstly codes and meaning units constituting each potential theme were re-examined to ensure that they formed robust patterns which cohered meaningfully while at the same time being distinct from one another. Secondly, patterns across themes were examined in order to form a final thematic map. As described by Grbich (2007), this step of analysis involved a process of reorganising, merging, and dropping initially identified themes, and then checking back with the data to ensure that the themes contained in the final thematic map constituted a meaningful representation of the data. For example, in the final thematic map elements of the preliminary theme 'embodiment of dialogical space' were merged with 'slow pace; allowing time and space' to form the final theme 'spacing and pacing'. The final thematic map is presented in figure G2 below.
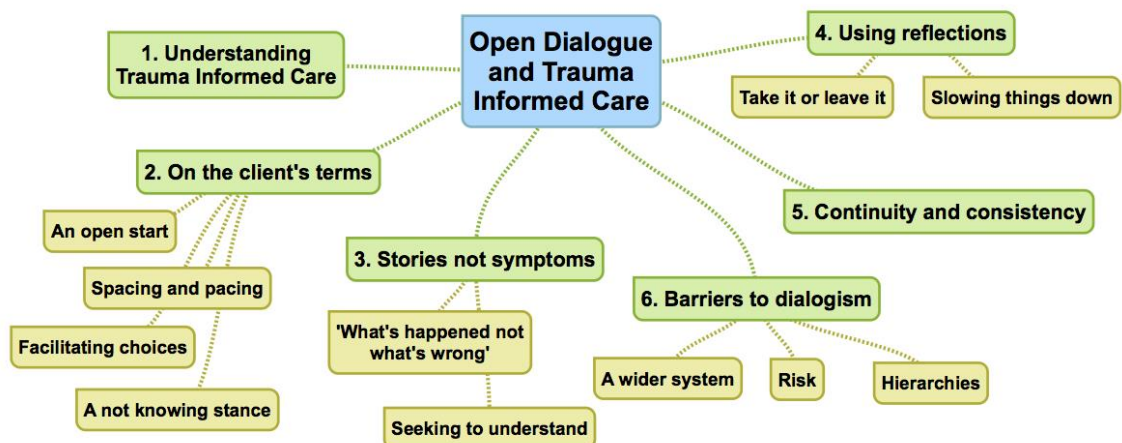

Figure G2. Final thematic map.

Step 5: Defining and naming themes.

The fifth step of the process was to make final refinements to theme names and definitions. This again involved a discussion between all authors. A number of considerations were made in this regard, for example the theme of 'continuity and

consistency' was originally called 'the same team throughout', but was renamed following discussion between the authors as it was felt, when the constituent data was again consulted, that the this final theme name captured the essence of the content in a more elegant manner. Final theme names, definitions, and illustrative quotations are presented in Appendix J.

Step 6: Producing the report

The final step of the process was producing the paper presented in the main document above. The key aim of this step was to provide a clear, coherent, and evidenced account of the data and involved two main tasks, again undertaken in the context of author discussion: selecting the order in which themes would be outlined, and identifying which selected quotations would be used to illustrate the final themes.

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Appendix I: Final themes, theme definitions, and illustrative quotations

Table II. Theme names, definitions and example quotations.

Theme Name	Definition	Illustrative quotation
Understanding Trauma Informed care	Practitioners discussion about their understanding of trauma informed care.	P14: I think many of the people we see, probably the majority of the people we see, have experienced some sort of trauma in their lives and we have to take that into account in the interactions that we have with them.
		P12: I think it [TIC] says the experience of young people with unusual experiences or experiencing psychiatric crisis often come in with a history of trauma and that they're experience is a way of trying to resolve some of those difficult experiences in the past or currently.
		P11: I guess my understanding of Trauma Informed Care...it's a clinical understanding from my work...it's very clinically based and it's based on all on my work with children and young people and adults who've had a significant experience of trauma and neglect.
		P3: I feel that trauma informs every aspect of my work...but it's never been, it wouldn't be used in the sense of those three words Trauma Informed Care...I don't use it as a term.
On the client's terms		
An open start	References to attempts to allow clients attending the service to determine their own path through treatment.	P10: what we do is to not having kind of initial interviews of clients. We prefer to have...quite open questions...not to specifically start having interviews about the life history or so called symptoms...the emphasis is on talking about what people want to talk about...aware of ideas of...possibility to re-traumatise when you kind of make people talk about the issues they don't want to talk about.

Spacing and pacing.	References to the slow pace at which therapy is ideally conducted.	P4: when there's trauma, you need time for that person...to find the words. And that might not be quick...It might be [the] second, third, fourth session...we can't force people to talk about their trauma. All you can do is create a space where they might be able to find the words or explore their feelings. But you can't force it.
Facilitating choices.	Discussion of the manner in which clients are facilitated in making choices about instrumental aspects of therapy.	P10:...we can talk about the...content issues, but also to think together about how we should proceed, and who should meet whom, and what do they feel is comfortable. P6:...for somebody who's been traumatised, they've been traumatised by a position of powerlessness, so how can that person feel that they have control of when the meetings happen, where the meetings happen?...having some people not in the room...that choice is really critical; that they feel in charge of who's present...and that we don't presume to know who should be in the room but they determine that.
A 'not knowing' stance	References to attempts made by professionals to put aside their own knowledge and assumptions to facilitate client choices.	P6:..it's that idea of we just don't know [what might be helpful]...because people's stories are so complex, and have been going on for a long time, and involve so many nuances, and everything is so individual...[it's important] to be curious about what people's ideas of their own needs are, their own ways forward.

P10: I might...draw from my own experiences or from professional ideas, but I don't consider them being really kind of truths...I want to bring openly under the scrutiny of other people...So it's really that 'I got this thought, but I'm not sure what you're thinking about these thoughts.'

Stories not symptoms

'What's happened not what's wrong'	Discussion of understanding presenting difficulties in the context of the clients history.	P12: For me the big difference [between OD and TAU]...is the non-pathologising of the individuals response to trauma. It's not some deficit or something wrong with the person. It's a human response to something in their life. And so we're really trying to move it away from something is wrong with them and more into something that happened to them.
A shared understanding	References to the manner in which practitioners facilitate the uncovering of the client's narrative.	P9: For me the big difference [between OD and TAU]...is the non-pathologising of the individuals response to trauma. It's not some deficit or something wrong with the person. It's a human response to something in their life. And so we're really trying to move it away from something is wrong with them and more into something that happened to them"
		P4: "You might go on to think about what's going to be helpful in terms of treatment, but that comes someway down the line...[following] those initial sessions of really truly understanding what has happened to this person, what has happened to them in the context of their network, their family.

P8: I suspect a trauma-informed approach...would have some sort of a theoretical understanding of how people behave or how interact as being specifically related to trauma...whereas the dialogical approach...tries not to cross that bridge about assuming why people...behave in a certain way...So the dialogical practitioner would talk about allowing a narrative of trauma to unfold if that's how the person chooses to see it.

Using reflections

Take it or leave it	Discussion of reflections as tools to allow clients freedom to take or leave practitioners ideas.	P13: I think that all the clients have said that the reflection is the key thing that's amazing because it stops the power inequality...It's a conversation that you're actually having with another colleague....the client's an observer to that, so they're not under any direct pressure...the spotlight's not actually on them and they're able to observe and process what's actually being spoken about in front of them...then it's their choice, if they then want to, when they reflect back, if they want to then add to that dialogue.
Slowing things down	References to reflections as a tool for regulating the emotional intensity of sessions.	P11: It [reflections] gives them [the network] a break. And if I think about when I do reflections, it's when things are getting anxiety starting to rise, when there's any form of emotion as well, in the family or a member of the family, it's a way of marking that without, again, without sort of coming face to face with it, which, yeah, seems to be incredibly helpful.
		P4: It takes away an intensity, which sometimes people are sharing traumatic experiences, there's an intensity in the room, and sometimes taking a reflection to give people time to just breathe and hear what we've heard, what we felt, and that can be really helpful. It kind of slows things down.

Continuity and consistency	Discussion of the OD principle of psychological continuity in the context of individuals presenting with trauma histories. This theme also included barrier to the implementation of this principle.	P12: I think what it does [psychological continuity] is help to avoid or at least to reduce having people with trauma histories, or any person who is seeking help, to not have to retell their story to lots of different people in a way. That can be confusing, it can be upsetting, and it can mean they don't feel heard or understood. P12:...it's not always possible in a complex social health services system like ours which might interface with lots of different parts of our service like in-patient services or other community services so it's not as integrated as we would like. P13:…within Open Dialogue teams, you're not supposed to change the members of the team. But the way that it's set up, the members of the team kept on changing...So even though we're all doing an Open Dialogue, it's not Open Dialogue Open Dialogue...because they're not set up like the team in Finland.
Barriers to dialogism		
A wider system	References to issues present in the delivery of OD due to the context and wider system within which network meetings occur.	P11:…our service is in other services. One of the very great difficulties is where, as a clinician...we are very intent on not re-traumatising the people we work with, but the organisations above us aren't quite so bothered by that.

Risk	Discussion of the impact of risk in sessions and the fact that this element makes it more likely for systems outside of the network meeting to take over.	P12: The stronger the amount of worry in the system around safety. When extreme behaviour is difficult to manage; to do with expressions around ideas of hurting self or hurting others that can really push systems into taking over.
Hierarchies	Discussion of barrier to the implementation of OD due to systemic pressures such as time and existing hierarchies.	P1: "The most difficult place to practice Open Dialogue is in hospitals...I wouldn't necessarily say that they don't want to do it because they don't like it or something, it's rather a question of time. Because you know for appropriate network meetings you should have one and a half hours and 90 minutes is like gold in a hospital. It is a luxury thing almost. So they hardly provide enough time for such meetings
		P13: I was working with a member of staff, he was a lot more senior than me, and he didn't want to stay. When you you're in a network meeting, you're supposed to be there until the end of whatever's being said. You're not supposed to put an agenda in, but he was putting an agenda in because he had another client to actually right go and see.

Appendix J: Author guidelines for Study 2 target journal

Author guidelines for the International Journal of Mental Health Systems

Aims and scope

International Journal of Mental Health Systems (IJMHS) publishes the latest mental health research and health systems research, reviews, case studies and guidelines, policy, debates, technical and methodological advances, and lessons from the field that will advance and shape the emerging discipline of global mental health. Advances in understanding of, and treatments for, mental illness frequently do not benefit those who most need them because of poorly developed mental health systems. Globally there is increasing attention to mental health legislation and policy, mental health system financing and governance, mental health service design implementation and evaluation, human resource development, effective translation of research to inform mental health policies and programs. IJMHS is committed to promotion and protection of the human rights of people with mental illness.

Research articles are reports of data from original research.

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Preparing your manuscript

The information below details the section headings that you should include in your manuscript and what information should be within each section.

Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page

The title page shoud present a title that includes, if appropriate, the study design e.g.: "A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"or for non-clinical or non-research studies a description of what the article reports. List the full names and institutional addresses for all authors. If a collaboration group should be listed as an author, please list the Group name as an author.

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• indicate the corresponding author

Abstract

The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:

• Background: the context and purpose of the study
• Methods: how the study was performed and statistical tests used
• Results: the main findings
• Conclusions: brief summary and potential implications

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Keywords

Three to ten keywords representing the main content of the article.

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The Background section should explain the background to the study, its aims, a summary of the existing literature and why this study was necessary or its contribution to the field.

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The methods section should include:

  • the aim, design and setting of the study
  • the characteristics of participants or description of materials
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  • the type of statistical analysis used, including a power calculation if appropriate

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This should include the findings of the study including, if appropriate, results of statistical analysis which must be included either in the text or as tables and figures.

Discussion

This section should discuss the implications of the findings in context of existing research and highlight limitations of the study.

Conclusions

This should state clearly the main conclusions and provide an explanation of the importance and relevance of the study reported.

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- Ethics approval and consent to participate
- Consent for publication
- Availability of data and material
- Competing interests
- Funding
- Authors' contributions
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Article within a journal by DOI

Slifka MK, Whitton JL. Clinical implications of dysregulated cytokine production. Dig J Mol Med. 2000; doi:10.1007/s801090000086.

Article within a journal supplement

Frumin AM, Nussbaum J, Esposito M. Functional asplenia: demonstration of splenic activity by bone marrow scan. Blood 1979;59 Suppl 1:26-32.

Book chapter, or an article within a book

Wyllie AH, Kerr JFR, Currie AR. Cell death: the significance of apoptosis. In: Bourne GH, Danielli JF, Jeon KW, editors. International review of cytology. London: Academic; 1980. p. 251-306.

OnlineFirst chapter in a series (without a volume designation but with a DOI)

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Complete book, authored

Blenkinsopp A, Paxton P. Symptoms in the pharmacy: a guide to the management of common illness. 3rd ed. Oxford: Blackwell Science; 1998.

Online document

Doe J. Title of subordinate document. In: The dictionary of substances and their effects. Royal Society of Chemistry. 1999. http://www.rsc.org/dose/title of subordinate document. Accessed 15 Jan 1999.

Online database

Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. http://www.healthwise.org. Accessed 21 Sept 1998.

Supplementary material/private homepage

Doe J. Title of supplementary material. 2000. http://www.privatehomepage.com. Accessed 22 Feb 2000.

University site

Doe, J: Title of preprint. http://www.uni-heidelberg.de/mydata.html (1999). Accessed 25 Dec 1999.

FTP site

Doe, J: Trivial HTTP, RFC2169. ftp://ftp.isi.edu/in-notes/rfc2169.txt (1999). Accessed 12 Nov 1999.

Organization site

ISSN International Centre: The ISSN register. http://www.issn.org (2006). Accessed 20 Feb 2007.

Dataset with persistent identifier

Zheng L-Y, Guo X-S, He B, Sun L-J, Peng Y, Dong S-S, et al. Genome data from sweet and grain sorghum (Sorghum bicolor). GigaScience Database. 2011. http://dx.doi.org/10.5524/100012.

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