

# **Democratic Approaches to Mental Healthcare in Which Therapeutic Relationships can Flourish**

By

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Portfolio submitted in fulfilment of the requirements of the Professional  
Doctorate in Counselling Psychology (DPsych)

City, University of London  
Department of Psychology

September 2017



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## **Acknowledgements**

Without the five families who shared their stories of open dialogue me, and the service-user who agreed for me to write a case study about him, this thesis would not have been possible. The experiences you have shared with me have been very valuable for this reason and I am deeply grateful to you all.

I am also indebted to the mental health professionals who gave me permission to carry out my research within the NHS trust, in which they were working. Without their support and the assistance of their colleagues, I would not have been able to advertise my research to the families who participated.

I am so very grateful to my supervisor, Dr. Aylish O'Driscoll, for her unrelenting and invaluable support in the production of this portfolio. She has consistently helped me to think about each stage of the process. Her unwavering positive attitude and her encouragement have helped me to find the courage to persevere with the multitude of challenges I have been faced with.

It is hard to imagine how I could have completed this portfolio without my wife. I have always loved her optimism and her humour; without her by my side, the trials of this project would no doubt have been much harder to bear. I am also very grateful for her patience with the multiple delays encountered in completing the portfolio. She has shown great strength and resilience in the face of my absence due to this project. Furthermore, over the last eight months she has supported me whilst working full-time and being pregnant! To me, she has been inspiring and a vital support, and I thank her with all my heart.

## **Declaration of Powers of Discretion**

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## Preface

This doctoral portfolio includes three sections: a) original empirical research, b) a publishable journal article and c) a psychological therapy case study. Together, they represent the final components of my qualification in counselling psychology (British Psychological Society, 2017). Although each section contains an independent piece of work, they are connected by their common valuing of a social network orientation to mental healthcare, which also values the therapeutic potential of relationships for those in mental distress. Rather than mental healthcare that focuses on professionals expertly intervening in individuals' lives, this portfolio explores mental healthcare as a more democratic approach, in which the relationships in a person's professional network and social network are assumed to play a significant role in therapeutic change. This focus concords with the counselling psychology values of exploring subjective and intersubjective experiences, and its valuing of offering of democratic, rather than hierarchical relationships (Kasket, 2012).

I began my career as a mental health professional working in an NHS psychiatric hospital, a setting in which service-users did not often seem to feel heard, and in which they were often isolated from their social network. My interest in alternative approaches to offering support to those with SMI grew out of this work, as I elaborate on in my opening reflexive statement in section A, but also from my interest in psychological understandings of mental illness. I was interested in how a person's life experiences and relationships may relate to their mental illness. I was particularly interested in psychotherapeutic approaches to recovering from mental illness. Having worked in a 'rehabilitation' ward, I had been afforded the opportunity to get to know service-users over long periods of time, often several years. The significance of their histories and their stories became ever more apparent to me. The stark reality of their exclusion from society and, it often seemed, their reliance on psychiatric language to explain their lives, often appeared to me to be limiting their opportunity for meaningful relationships in their life, which might help them in their recovery from their traumatised lives. Open dialogue, which I discovered by watching a documentary about it (Mackler, n.d.), seemed to offer the opportunity for service-users' stories to be shared and more clearly heard, by both professional and other support networks, like families. What this may be

like for NHS service-users and families was, therefore, of great interest to me, and this is the topic of my empirical research in section A. My hope is that this exploratory research will help professionals and others interested in the OD approach, to think about what further questions need to be asked about this alternative approach to mental healthcare, to learn more about how it might support recovery, as defined by each individual, and how it might support the social inclusion of people with mental illness.

In section B I have chosen to present my research in an article for the Journal of Family Therapy. This paper focuses on how the narratives of two of the families interviewed can be understood from the perspectives of humanistic psychology and compassion. The Journal of Family Therapy is interested in “understanding and treatment of human relationships constituted in systems such as couples, families, professional networks, and wider groups” (Journal of Family Therapy, n.d.). Furthermore, not only has this journal published articles on OD, but it is published on behalf of the Association for Family Therapy and Systemic Practice, which accredits a foundation level OD course in the United Kingdom (UK). It claims to be “one of the most widely read family therapy journals” (Journal of Family Therapy, n.d.) and it has an impact factor of 1.186, so I hope my research will be read by a substantial professional audience if published in this journal. I will also be sharing the results of this research with the families who participated in it. I hope to have the opportunity to share my findings with other service-users and families, who may also wish to learn about how OD has been experienced by some of its users.

In section C I have presented a psychological therapy case study of the work I did with a young man who presented with depression. This used a time-limited cognitive behaviour therapy (CBT) approach, which incorporated systemic aspects into the client’s psychological formulation (Koch, Stewart and Stuart, 2010), and a ‘third wave’ CBT approach that used attention training (Wells, 2011), mindfulness (Strosahl and Robinson, 2008) and compassion (Gilbert, 2009). I found that fostering a service-user’s attitude of compassion towards themselves can enable them to both observe and accept their experiences, so that they can choose to respond to distressing experiences in a more helpful way. This study helped me to consider how the therapeutic relationship I had with my client was used to support him in his recovery from mental

illness. Given that this study used time-limited therapy, what was particularly pertinent about the systemic focus I took was that it helped the service-user to revise how he can best seek support from his social network, as and when he might need it over his lifetime. This issue of how therapeutic change can be sustained, and how wider social structures, like families, may play a part in this, is also discussed in my research.

Part of my journey to becoming a counselling psychologist is represented by this body of work. Although I have found the research process highly challenging as a researcher, I have learnt how valuable qualitative research can be for exploring people's experiences and for facilitating thought about these. Through both my research and case study, I have learnt how useful involving families in mental healthcare can be, and how mental healthcare can function as a facilitator of therapeutic dialogue within a person's social network. Through my research I have also come to appreciate more profoundly how mental healthcare can inhibit some people's recovery from mental illness. I am really pleased to be able to offer this research, as it is my hope that the voices of the families it aims to represent will contribute to an ongoing discussion about what is most valuable in mental healthcare for SMI. As a clinical practitioner, by reflecting on my practice, I have come to respect more fully how systemic practice and compassion can be important approaches to foster in psychological therapy.

Throughout both my work as a researcher and as a clinical practitioner, reflection on my practice and on how my subjectivity may be affecting this, has been the core process through which I have been able to develop, both professionally and personally. Rizq (2006) suggests that the counselling psychology trainee needs to develop confidence in their practice of considering a plurality of theoretical viewpoints, and of considering viewpoints about one's self and one's intersubjective experience with another. As a researcher, I have had to be aware of how my subjectivity may be affecting my participants' expressions of their subjectivities; as a clinical practitioner, I have had to be aware of how my subjectivity may be interacting with the client's subjectivity in the therapeutic relationship. This intersubjective and theoretical awareness describes the demanding process, which I have gone through in both my clinical and my research work. I am grateful for these perspectives and this reflexivity, however, as I believe they have really assisted me in my ongoing ambition to truly understand and help people in

mental distress. The apparent importance of a dialogue, in which multiple voices can be heard, for understanding people, interestingly, appears to be similar to the intrapsychic process described above. The potential therapeutic value of such an interpersonal dialogue is a key perspective that I take from this portfolio, which may contribute to the future direction of my career.

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## Acronyms Used and Definitions

Acronym	Definition
NHS	National Health Service
SMI	Severe mental illness
OD	Open dialogue
POD	Peer-supported open dialogue
CMHT	'Community Mental Health' Team
CRHT	'Crisis Resolution and Home Treatment' Team
EIP	'Early Intervention in Psychosis' team
NICE	National Institute for Health and Clinical Excellence

## **Terms Used and Definitions**

### Severe Mental Illness (SMI)

The National Service Framework for Mental Health (Department of Health, 1999) describes people with SMI as those with 'recurrent or severe and enduring mental illness' with complex needs, who may be able to live safely with their families in communities, but may also need the support of specialist mental health services, as well as other support agencies. Within this broad definition, people may have been diagnosed with any of the various psychiatric diagnoses.

### Social Network

I use this phrase to describe the non-professional social relations a person may have. This could refer to their family, friends or both.

### Service-User

This phrase is widely used in the National Health Service (NHS) to refer to someone who is using a mental healthcare service. Families who use open dialogue (OD) could, therefore, be called service-users. I will use this term, however, to identify those persons with SMIs who originally needed mental health support, which led to them and their social network being offered OD.

### Open Dialogue User

I use this phrase to refer to any member of the non-professional social network that has used OD, including the service-user.

### Monological Dialogue and Dialogical Dialogue

The kind of dialogue where the person is treated as a passive recipient of the professional's intervention can be understood as monological rather than dialogical: "Interpersonally, monologue involves silencing the other by domination or by control of the available means of explanation." (Seikkula and Trimble, 2005). Dialogical dialogue, in contrast, can be identified as respecting the following principle: "that every utterance calls for a response in order to have meaning, team members strive to answer what is said. Answering does not mean giving an explanation or interpretation, but rather,

demonstrating in one's response that one has noticed what has been said, and when possible, opening a new point of view on what has been said. This is not a forced interruption of every utterance to give a response, but an adaptation of one's answering words to the emerging natural rhythm of the conversation." (Seikkula and Trimble, 2005).

### Idiographic

This term refers to an approach to research which instead of aiming to produce knowledge that can be objectively applied to many people in different contexts, beyond those who participated in the study, aims to understand the personal, subjective and unique meaning or experience of those who have participated in the research.

Upon reflection I have realised that some of the terms I have used in this thesis might not be the language that some readers would prefer to use. As a mental health professional I have tended to use the language that is commonly used in professional discourse, but I appreciate that other language may be more acceptable to some readers. I would like, therefore, to suggest some alternatives to some of these potentially contentious terms, to help the reader to consider their preference. Please see table 1 below.

<b>Terms Used</b>	<b>Alternative terms or phrases</b>
Mental illness	Mental health condition
Severe mental illness	A mental health condition, which at times can be particularly overwhelming.
Suffering	Experiencing
[The professional team] in charge	Helping facilitate
Open dialogue user	The person engaging with open dialogue

**Table 1: Alternative terms for the reader to consider**

## References

Department of Health. (1999, September 10<sup>th</sup>). National Service Framework for Mental Health. Retrieved from

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/198051/National\\_Service\\_Framework\\_for\\_Mental\\_Health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf)

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## **SECTION A: DOCTORAL RESEARCH**

The Experiences of Families Using Open Dialogue in  
the National Health Service: A Critical Narrative  
Analysis

### **Abstract**

An alternative approach to mental healthcare for severe mental illness called 'open dialogue' (OD) is currently being trialled in the NHS. My research used a qualitative approach to develop understanding about the experiences of five families who had been using OD in the NHS. Each family was interviewed as a group and critical narrative analysis was used to analyse each family's experience. This resulted in a series of idiographic narratives, which were then considered from the theoretical perspectives of empowerment and objectification. The findings are then explored from the perspectives of humanistic psychology and compassion. Possible applications of the research for the practice of OD are considered for professionals and users. Applications for the practice of counselling psychology are also considered, and ideas for future research are suggested.

### **Personal Reflexivity Statement**

Kasket (2012) proposes that a researcher's personal interests in a research topic should be reflected upon by him/herself prior to commencing the research, to identify how these interests may affect the research and what the researcher might do to reduce any unacknowledged bias throughout the research. I hoped that an early personal reflection in this report would help the reader attune to this research and my commitment as a researcher, and, thereby, make the research process more transparent and coherent, factors that Yardley (2000) suggests can help validate qualitative research. In this vein I chose to write this research report in the first person to allow the readers to position themselves towards the research, as much as possible, from my perspective.

Having worked for several years as a nursing assistant and counselling psychology trainee in an inpatient setting in an NHS psychiatric hospital, I began to develop critical opinions about NHS care for those with the most severe mental illnesses (SMI), and, often, the most complex and enduring difficulties. I worked with, and got to know, many service-users who had been in and out of inpatient psychiatric services for many years. The psychiatric hospitals and NHS community mental health services seemed to be a temporary and often unsatisfactory support network for its service-users. Although the biopsychosocial model (Engel, 1977) was in use, medication seemed to be the predominant intervention. It seemed that many people felt stuck, powerless and resentful about the treatment they had received. Although some did have supportive friends or relatives, many also had fractured social networks. Consequently, I became increasingly critical of the use of psychotropic medication for SMI as it seemed to be an ineffective long-term therapy. Critical literature I had read supported this observation (Moncrieff, 2007). It also became clear to me that compassion and empathy go a long way to helping people who have been very unwell for many years. My pursuit of alternative models of care than that with which I had been working led me to discover OD and, also, organisations led by those who had experienced mental health difficulties, such as the Hearing Voices Network. It seemed that these alternative approaches, apparently offering people a chance to share their experiences of mental illness more freely and beyond the parameters of the traditional healthcare model, offered a more compassionate and meaningful support system than that currently available in the NHS.

It was my impression from this experience that little effort went into helping service-users to develop more supportive social networks, beyond placing them within further professional networks in the community. Although there was an evidence-base for family interventions in psychosis (e.g. Pharoah, Mari, Rathbone, and Wong, 2010) and such interventions are recommended by NICE (2014), it seemed that their availability is limited in the UK (Kuipers, 2011). I was also curious as to the provision of systemic support of this kind for other SMI sufferers than those with psychoses. I wondered whether compassionate network-orientated approaches, like OD and the Hearing Voices Network, could be adapted for use with other SMIs and whether they would be useful more widely. Inspired by alternative approaches and the idea that intervening earlier in mental illness could be more effective, I was interested in whether the NHS could help foster more sustainable support-networks than it currently provides.



## **Chapter 1: Introduction**

*“Listening attentively aims at hearing what our clients are saying. Hearing is witnessed in our answering words. We do not plan in advance our next question, or even the interview as a whole, but, instead, the next question is created in the answer of the clients. In this way, [everyone] can experience how to become an agent in the new story of their suffering.” (Seikkula, 2002).*

The quote above describes the aimed for process and outcome of a therapeutic approach for mental illness, now known as ‘open dialogue’, which primarily aims for dialogue within social networks rather than symptom reduction. The widespread manner in which OD has been adopted by the Finnish mental healthcare system has been reported mostly in descriptive studies, rather than randomised control studies, based on attempts to produce explanations of OD which have wider application (Seikkula and Arnkil, 2014). Since social context is of particular importance to OD, descriptive studies that take this into account are claimed to be more useful for people in these contexts than the broadly applicable theories of practice produced by research that aims to explain clinical practice. (Seikkula and Arnkil, 2014). In this study, I hope to elaborate and, so, develop understanding about the experiences of families who have been using OD within the NHS, in order to make their voices heard in the ongoing dialogue about the use of OD in various contexts within the NHS. This research is supported by a literature review of research findings from around the world on the processes and outcomes of local implementations of OD.

### **Overview**

First, I will first introduce the reader to the OD approach to mental healthcare. I will explain how this contrasts with traditional NHS mental healthcare and describe how OD is being used currently in the NHS. I will then present my review of the relevant literature, before presenting my research.

### **The Development of OD in Finland**

Open dialogue originated in the Western part of Finnish Lapland in the early 1980s (Seikkula, 2015). Jaakko Seikkula, professor of psychotherapy, clinical psychologist and

family therapist focused his clinical practice and research on the development of OD in Finland and is one of the key proponents of the approach. Seikkula and Arnkil (2014) explain how 'open dialogue' was first used as a name in 1995 (in Seikkula et al., 1995). It was used to refer to the social-network centred meetings it utilised, as well as the principles it advocated for enabling dialogue within the entire psychiatric system. Seikkula (2015) describes how OD was based on the Need-Adapted Treatment model (NATM) for psychotic patients and their relatives, developed in Finland in the late 1970s (Alanen, 1997). This emphasised the unique process of each person's treatment and, therefore, how it should be tailored to the person's needs. It integrated psychodynamic therapy and family approaches. Alanen, Lehtinen, Rääköläinen, and Aaltonen (1991), and Alanen (1997) described the following key components of the approach: 1) Quick early intervention, 2) professionals and families meeting together so that the changing needs of both the service-user and their family can be identified, 3) the use of a 'therapeutic attitude', a focus on both the historical and present experiences of the family, the professional using both observations of their emotional reactions and others, 4) treatments decided upon being fully concordant with each other, and 5) The potential need to change the treatment being continuously assessed. From 1981 to 1987, the Finnish National Schizophrenia Project aimed to develop community treatment instead of inpatient treatment (Tuori et al., 1992). It resulted in 63% less long-stay schizophrenic patients in hospital and community crisis teams being available to 50% of the country. Razzaque and Stockmann (2016) describe how NATM integrated narrative, systemic and constructivist features, which ultimately led to it replacing family therapy in hospitals in 1984. They highlight how NATM struggled to engage families with its approach of professionals playing the role of key instigators of systemic change. They explain how this led to professionals making less of an attempt to implement change in the family; in other words, 'doing to' practice was gradually replaced with more 'being with' practice. One such example is highlighted: influenced by Anderson (1990), the traditional family therapy method of a one-way observation mirror was discarded in place of open shared observation in the room with families, instead of privately formulated observations. In the context of the NATM and crisis community teams being more prominent, not only was there a need for a model of co-ordinating care, but there was a need to understand the process in dialogue of 'being with' rather than 'doing to'. Out of this OD was developed.

Seikkula (2015) explains that both the dialogic processes and treatment outcomes of OD have been rigorously evaluated since its initial development. It is from these evaluations, he explains, that the seven principles of OD that I describe below were formed. He emphasises that these principles were not decided upon a priori. He states that “[t]he approach is not diagnosis specific, but an entire network-based treatment that is especially practical in crisis situations.” It is, perhaps, due to this applicability, along with the remarkable outcome data of OD in Finland, detailed in the literature review below, that countries around the world have begun to adapt OD to their particular needs and to describe and evaluate its therapeutic value. Razzaque and Stockmann (2016) report implementation as having begun in other Scandinavian countries, Germany, Ireland, Italy, Poland, several states in the United States of America (USA), as well as in the UK.

According to Seikkula et al. (2003), OD, originally designed for psychotic service-users, is a service model approach that aims to arrange a meeting between professionals, those in mental health crisis and their social network members, within 24 hours of the crisis. It uses a dialogical, non-hierarchical and communal way of openly discussing the mental health issue. The multiplicity of voices in any one dialogue, as conceived by Bakhtin (1984), is a key underlying assumption of OD (Seikkula et al. 2003). How this “polyphony” of voices manifests in dialogue is considered to be a key factor in understanding about mental illness can develop (Seikkula and Trimble, 2005). Seikkula and Trimble (2005) argue that the key healing elements of any therapy are being heard, responding to someone else and knowing that the response has been received. They suggest that the degree to which OD service-users experience the many voices within this dialogic framework will determine the extent of their psychological change. The trained multidisciplinary OD team consists of the same professionals throughout the period of the social-network’s care. No discussion about treatment happens outside of these meetings. Treatment planning is a collaborative approach and, therapies, or other interventions, for individuals are arranged in addition to OD as needed. Razzaque and Stockmann (2016) clarify that OD is “both a therapeutic model and a method of organising services”. They highlight how, of the seven guiding treatment principles (see below), principles one to five are relevant to the organisation of OD and principles six and seven are related to how OD is practiced. In the Finnish province where the

approach was developed, the organisational principles of OD have been integrated into the orchestration of the entire social and healthcare service (Seikkula et al. 2003). The seven guiding treatment principles of OD are as follows (Seikkula et al. 2003):

- 1) Immediate Intervention: The person in crisis is met by the professional team within 24 hours of referral, with the aim of preventing admission to hospital.
- 2) Social Network Perspective: The most significant people in a person's social network are gathered.
- 3) Flexibility and Mobility: The type and context of therapy is adapted to the need. Treatment planning commences more formally once the crisis has abated.
- 4) Responsibility: The first mental healthcare professional contacted has responsibility for organising the first meeting. The professional team is then in charge of the entire treatment process.
- 5) Psychological Continuity: The same multidisciplinary professional team works with the social network throughout the entire treatment process, for as long as the crisis requires. For psychotic service-users this is usually around two years.
- 6) Tolerance of Uncertainty: Relationships are developed in which all parties can feel safe; this may be helped by more regular meetings. If and when another meeting is required, it is jointly discussed at each meeting by everyone present. Time is taken to discuss important decisions, jointly; whether to use medication for example is something that is discussed over several meetings.
- 7) Dialogism: The professionals' primary aim is to follow the content and process of OD users' conversation, by compassionately respecting each utterance and making space for all possible voices (Seikkula and Trimble, 2005). Secondly, an increase in users' understanding about the mental illness and an increase in their sense of identity, or 'agency', is aimed for.

## **The Introduction of OD to the NHS**

As in Finland, but dating back to the 1950s, there has been a significant move in the NHS from treating service-users in psychiatric hospitals to treating them in the community (Marlone, Marriott, Newton-Howes, Simmonds, & Tryer, 2007). This has led to the development of community-based mental health teams, such as 'crisis resolution and home treatment' teams (CRHTs) for supporting people during an acute episode of mental illness outside of a hospital setting, and 'community mental health' teams (CMHTs) to support people in their ongoing recovery and to reach out positively to those with a history of not engaging with mental healthcare services. Although care pathways may differ to some degree from NHS trust to NHS trust and evidence-based care pathways for SMIs are currently in development ("Crisis and Acute Care for Adults", n.d.), it is my understanding that NHS approaches to treating SMIs fall within the following broad description: If someone seems to be at the point of crisis in respect of their mental health, then they can either be assessed by a CRHT, or by a 'Psychiatry Liaison' team at a hospital Accident and Emergency service, or by professionals at a psychiatric hospital. If their risk to themselves, others, or indeed, from others is deemed to be high enough, then, if they do not consent to being admitted to hospital, they may be sectioned under the Mental Health Act (2007) for assessment or further treatment. If the risk to themselves is lower, then they may be offered community treatment from a CMHT or a specialist mental health team, such as an 'Early Intervention in Psychosis' team (EIP). Throughout all these 'tiers' of care, pharmacological and psychosocial interventions are used, as recommended by NICE. Psychosocial interventions including psychological therapies, occupational therapies and, sometimes, where indicated as helpful, family interventions e.g. for psychosis, are also used (NICE, 2014).

Systematic reviews of research into the effectiveness of CMHTs, CRHTs and EIP services highlight the limited data available and identify a need for more research in order to be able to discern their effectiveness, or otherwise (Marlone et al., 2007; Marshall and Rathbone, 2011; Murphy, Irving, Adams, & Waqar, 2015). The studies available have identified that CMHT and CRHT service-users found it acceptable to be treated in the community or their own home. Within the CRHT systematic review the experience of professionals and the experience of carers is not assessed. 'Burn-out' of professionals is, however, noted to be frequent. This individualistic rather than systemic perspective is

in agreement with Razzaque and Stockmann's (2016) assertion that most NHS mental healthcare is tailored to the service-user's needs rather than the needs of the social network more broadly. Another common approach in the NHS identified by Razzaque and Stockmann (2016) is that of professionals using 'templates and internal algorithms' to help them decide how to respond to people: which information needs imparting and which needs extracting. This could be described as monological dialogue and is akin to the 'doing to' practice described above, rather than 'being with' the person, or people, in what is interpersonally felt at that moment. Although it seems, from the systematic review above, that EIP services are effective, there is some suggestion that the benefits of being a user of the service may not be maintained when a person is discharged. The effectiveness of early intervention in psychosis' using OD in Finland has in contrast, been maintained 10 years after the approach was used (Seikkula, Alakare, & Aaltonen, 2011). By focusing on supporting a social network via dialogue, rather than an individual with a more monological management, OD offers the NHS the potential to affect more sustainable change from the point of crisis. The difference between OD and what is currently offered by NHS services for SMI, is supported by observations from both professionals and service-users (Razzaque and Wood, 2015).

By re-adopting Hoult et al.'s (1984) key principles for good CRHT practice (early intervention, responding rapidly, a systemic approach at the patient's home, consistent care from the same team and ongoing rather than time-limited help), providing specialised training for multidisciplinary NHS professional teams, encouraging flexibility and joint working across teams and including peer-support, Razzaque and Stockmann (2016) describe how it is hoped that OD can be applied to community-based NHS mental healthcare for acute presentations. As well as adapting the seven key OD principles outlined above to the NHS, the proposed approach emphasises the importance of professionals practicing moment-to-moment awareness and acceptance of the thoughts and feelings of OD users, as well as practicing such awareness of their own responses to the users. Razzaque and Stockmann (2016) explain how awareness and acceptance can help clinicians to be more emotionally attuned to the content and process of a dialogue. By encouraging the service-user and their social network to develop their own understanding about the mental health issue, the approach aims to empower its users to help themselves to recover (Razzaque and Stockmann, 2016).

Several NHS trusts are piloting OD. Like other crisis services based on OD principles, such as the Parachute New York City service (Coe, 2013), the plan in the UK is to include peer-support in the application of OD in the NHS (Razzaque and Stockmann, 2016). The term 'peer-support' in mental health refers to support provided by people who themselves have experienced mental health difficulties and can include both emotional and practical support (Gartner & Reissman, 1982). Open dialogue in the NHS is thus called 'Peer-supported Open Dialogue' (POD). The application for funding from the National Institute for Health Research for a national randomised-control trial of POD was reported at the National POD Conference in March 2017 to be in the final stages of approval. This trial will use relapse rates as a primary measure of treatment success and compare outcomes with those after 'treatment-as-usual' (Razzaque and Stockman, 2016). Since 2015, NHS trusts have been training small teams of professionals in POD and arranging for them to pilot OD in several CRHTs and CMHTs. The peer-support aspect of POD, however, had not been integrated into these pilot teams when I was carrying out my research. Henceforth, when referring to POD as practiced without peer-support, I, therefore, refer to it as OD.

## **Literature Review**

I was interested to research applications of the OD approach around the world. Since there is neither a treatment protocol for OD nor a universal training route (Seikkula 2015), OD's wider applicability to mental healthcare may vary in different contexts and according to differences in sociocultural context. If implementation of a dialogically orientated and social-network approach to mental healthcare, influenced by the principles of Finnish OD (Seikkula et al. 2003), was being reported, then I have included research in the classification of 'OD'. I have also analysed my literature review in respect of (1) outcomes of OD, such as symptom reduction, and (2) the process of OD, i.e. how dialogue occurs and how OD is experienced by its users.

Using the online academic database search engine EBSCOhost, I searched for relevant literature across the following databases: Health Policy Reference Center, MEDLINE Complete, PsycARTICLES, PsycINFO, CINAHL Plus with Full Text and SocINDEX with Full Text. I did not restrict the search by year of publication. I used the following search terms: 'open dialogue'; 'dialogical mental health'; 'open dialogue experience'; 'open

dialogue UK/United Kingdom/NHS/National Health Service'; 'peer-supported/peer supported open dialogue'. In order to identify my research question when developing my original research proposal, I first carried out this literature review at the end of 2015. I then updated it in early 2017. Given the infancy of OD, I also searched for information and viewpoints about OD through the Google search-engine, using the search term 'open dialogue'. To differentiate these sources from peer-reviewed sources, I have marked their citations with an asterisk. I also identified further relevant literature via citations within the above literature. Buus et al. (2017) provide a literature review of what has been published about OD in Scandinavian countries other than Finland, where they suggest OD has been adopted most widely. Where the publications they reviewed were not in English, my critique was limited by only having access to this secondary source, as I do not read any other language but English.

### Outcome Research

Finland has produced the most substantial body of OD outcome research. Whereas other countries are only just beginning to publish preliminary findings, the first OD outcome study in Finland was published in 2001. I, therefore, focused initially on this foundational research, before commenting on more recent research from Denmark and the USA, and how the latter related to what had already been published from Finland.

Preliminary evaluation of OD by Seikkula, Alakare and Aaltonen (2001) highlighted characteristics of good and poor outcomes of the approach, based on service-user functioning and psychotic symptoms, using both quantitative and qualitative methods. Good outcomes were associated with reduced neuroleptic medication use and hospitalisation. Poor outcomes were associated with more complex psychotic symptoms prior to treatment and a lower quality social network prior to treatment. Poor outcomes were also related to the reduced use of dialogue about the mental health issue during treatment, even when pre-existing social and psychological factors were not predictive of a poor outcome. Whether OD is suitable for all SMI presentations and all social networks is questionable given this finding. How useful dialogue develops is an important question raised by this research.



Seikkula et al. (2003) published a two year follow-up, using outcome measures typically used for first episodes of psychosis research, to compare the outcomes of two patient groups who had been treated for their first episode of psychosis. Both patient groups were from the same Finnish district. The first had been given an earlier less comprehensive version of OD, whereas the latter group had been given a later version of OD. Outcomes were compared historically. These patient groups were also compared with another first-episode-psychosis patient group, which received a more conventional approach, based on hospitalisation and medicalisation treatments. This approach had been used during the same time period as the less comprehensive version of OD. This 'comparison group' was from another Finnish district, but it was ethnically similar (90% Finnish). In contrast with the comparison group, the OD patient group had shorter hospitalisations, fewer relapses (24% vs. 71%), significantly less residual psychotic symptoms ( $p < .05$ ), and were significantly more likely to be employed ( $p < .001$ ). Open dialogue, therefore, appears to be significantly more effective than conventional treatment for first-episode of psychosis. The second OD patient group also had significantly less psychotic symptoms than the earlier OD patient group ( $p < 0.05$ ). Subsequently however, a 5-year follow-up of the first OD and second OD patient groups (Seikkula et al., 2006) identified no significant differences in psychosis symptoms: 76% of the earlier OD group versus 82% of the later OD group had no residual psychosis symptoms. Seventy percent of the earlier OD group and 76% of the later OD group had returned to work or education. Twenty-seven percent of the earlier OD group and 14% of the later OD group were on disability benefit. Over the 5-year period, 29% of the later OD group relapsed versus 39% of the earlier OD group, although this difference was not statistically significant. Only 29% of the later OD group had used neuroleptic medication during the 5-year period, compared with 39% of the earlier OD patient group, although these differences were not statistically significant. The average duration of untreated psychosis in the later OD patient group was 3.3 months, compared with 4.2 months in the earlier OD patient group, but this was not statistically significant ( $p = .069$ ). Although these differences between the two forms of OD were not significant, they do suggest a positive correlation between improved outcomes and more comprehensive OD practice. Furthermore, it appears that the earlier form of OD took longer to reduce psychotic symptoms than the more comprehensive version.

Looking at the same Finnish district as above, Aaltonen, Seikkula & Lehtinen (2011) showed that the mean annual incidence of schizophrenia had decreased 2 years after OD was introduced from 24.5 to 10.4 cases ( $p < 0.001$ ) and brief psychotic incidents had increased from a mean annual incidence of 1.2 to 6.7 cases ( $p = 0.025$ ). They found that there were no new long-stay schizophrenic hospital patients over this period. They found, however, that there was a significant increase in brief psychotic episodes. It was suggested that the treatment culture of the public may have become more open to engaging with the psychiatric services. Although this research did not have randomized control, it is argued that similar studies (Lehtinen et al., 2000; Cullberg, 2006; Alanen, 1997) suggest that treatment cultures change when similar approaches are applied (Aaltonen et al. 2011). This assertion is backed up by the large number of local inhabitants participating in treatment meetings (Seikkula et al., 2011). This study showed that 10 years after OD was introduced to this Finnish district, the prevalence of schizophrenia and psychosis had fallen, the duration of untreated psychoses had decreased to 3 weeks, and the positive outcomes of those who had used the OD approach remained consistent with the research outlined above.

Caution must be taken when interpreting the above research on Finnish use of OD, however, as it is based on a small sample size ( $N = 36, 46$  and  $18$  for the respective evaluation periods of 2, 5 and 10 year follow up, respectively reported by Aaltonen et al. (2011) and some of the differences observed did not reach statistical significance. The validity of this research has also been questioned because of the lack of randomization and the lack of a control group (Ross, 2013\*). Because of these methodological failings, a strong statement as to what caused the outcome improvements cannot be made. Another factor that might be contributing to the apparent effectiveness of the Finnish OD could be the consistency of the mental health staff for service-users. It might be that having opportunity to develop a relationship with mental health professionals, rather than continually meeting new staff, helps service-users and their families in crisis. The degree of support may also be an important factor in this apparent effectiveness. Being clear as to how this new approach has been effective is necessary before implementing major changes of treatment or moving funding from one service to another. It is obviously important to be certain that any improvement is due to the change in management concept, not simply to more

generalised improvements, such as the availability of resources. Olson (2014) describes how randomised testing was not possible in Finland when OD was being established because of the universal way it was integrated into the mental health system. The Finnish OD research is, therefore, descriptive rather than explanatory (Olson, 2014). It is only now that OD is being trialled in different systems, such as the UK NHS, that more rigorous testing of its effectiveness in relation to other treatment models can be implemented.

Whether OD can translate to other countries is an important question that has been raised (Thomas, 2011). If indeed OD is effective, sociocultural variables between cultures may play a part in whether it is useful to service-users elsewhere. One such factor in the effectiveness of OD in Finland which may not be reproducible elsewhere is the close relationship of mental healthcare and employment agencies (Olson, 2014). The high return to employment by Finnish OD service-users may have been related to the close working relationships between Finnish mental health staff and the local employment offices. Once someone begins to recover, this is communicated between the two agencies, increasing the likelihood of return to employment. It is not clear whether such cohesion exists in other countries and, therefore, to what degree early re-employment is possible for OD users in these countries.

Seikkula, Aaltonen, Kalla, Saarinen, and Tolvanen (2013) have demonstrated how the OD principles can be used effectively in couple therapy for depression. In a randomised control trial comparing this couple therapy with individual therapy they found a significant difference in favour of couple therapy in depression in respect of general mental health, social, occupational and psychological functioning, alcohol use and the number of therapy sessions needed. Seikkula and Arnkil (2014) observed how there was an even greater degree of recovery from depression and general mental health in service-users given couple therapy in Western Lapland in contrast to other Finnish localities, where OD principles had been embedded into the general mental healthcare practice. The question of how OD is experienced by a network of service-users when applied both as a therapeutic approach and as a way of organising healthcare is introduced by this study. This study also identifies a benefit to applying OD to psychiatric

presentations other than psychosis, and suggests a need for exploration of the application of OD principles in other psychiatric settings.

In Denmark, OD has been adopted by the social and mental health services. More specifically, OD has been used in a child and adolescent outreach crisis intervention team and a dual-diagnosis team. It has been used as a therapeutic service for service-users and as a method of encouraging collaboration between social and healthcare workers (Buus et al. 2017). Although the Centre for Public Health and Quality Improvement (2016 - cited in Buus et al. 2017) found that recovery and wellbeing had slightly improved, this research identified that quality of life had not changed. This study was based on a manualised implementation of OD with fidelity criteria. It used a before-and-after design and the above findings were based on half-way evaluations of 41 participants, of which 11 had completed treatment. Given that treatment had not been completed for most participants, it is too early to conclude that OD will not improve the quality of life of these participants. However, this early finding requires further scrutiny of the experiences of the remainder of these OD-users. If the final results are positive, this study will help show how OD can be implemented in child and adolescent, as well as dual-diagnosis, services, supporting the assertion that OD has broad applicability across the spectrum of mental healthcare services (Seikkula, 2015).

In the USA, Gordon, Gidugu, Rogers, DeRonck, and Ziedonis (2016) applied OD to a crisis team that operated in community settings and people's homes and published the first research on OD in the USA. Master's-level clinicians and a psychiatrist were trained in OD over two years. The study focused on a community-based implementation of OD. Rather than offering support in inpatient settings, if service-users were hospitalised, then the involved professionals remained in contact with the OD users and their inpatient healthcare providers. Over 12 months, quantitative measures were used to evaluate the feasibility of OD. The 16 participants were aged 14-35, had been experiencing psychosis within the last month, were not actively suicidal and had been able to provide informed consent to participate in OD. Significant positive changes were found in participants' symptoms, functioning (levels of depression and anxiety, and daily living skills), need for care, the average number of hours spent in work or education, and the average number of hospital days. Of six people not on medication, three were put

on it. Of eight people on medication, 4 opted to come off it. Outcomes for both groups of four were similar. This research supports the idea that OD leads to positive outcomes for its users. Although these outcomes are reported at only 1 year, rather than 2 years, after OD was started, the use of medication detailed above and its relation to outcomes does not seem to support the correlation between low medication use and positive outcomes observed in the Finnish outcome research (Seikkula et al., 2003).

In summary, although outcome research does support the idea that OD can be beneficial for SMI service-users and their families/social networks, there is currently a paucity of evidence to ratify this claim, with only one study so far having used control groups and randomisation of treatment. The small sample sizes of the above studies must also be factored into any consideration of how much these studies can really tell us about the effectiveness of OD. Furthermore, the information from Denmark and the USA are early reports of small-scale trials of OD that may still be in progress and the longitudinal effectiveness of OD in countries other than Finland remains uncertain.

### Research Into the Process of OD

Research on the process of OD seemed to fall into two categories: 1) how service-users valued the process of dialogue and 2) the experience of service-users of the relationships that developed in OD. I have, therefore, reviewed the literature from these two points of interest, before summarising what can be said from this literature about the OD process.

**The Process of Dialogue in OD:** In Finland, Seikkula (2002) used sequence analysis (Leiman and Stiles, 2001) to identify topical episodes in OD meeting transcripts. Participants were paired into good and poor outcome OD service-users, judged according to their subsequent vocational status and psychosis symptoms. Ten pairs of participants were matched for age, sex, degree of psychosis and social network impoverishment. The sequences of dialogue identified were then compared. In the good outcome cases, the service-user and their family members quantitatively dominated the dialogue ('spoke' most) in 55-57% of the sequences and semantically dominated the dialogue ('introduced new content' most) in 70% of the sequences, compared with only 10-35% of quantitative dominance and 40-70% semantic dominance in poor outcome

cases. In good outcome cases, as compared to poor outcome cases, there was more dialogical dialogue than monological dialogue (60-65% vs. 10-50%). Good outcomes seem to have been related to dialogues in which OD users dominated, and in which a dialogical dialogue rather than a monological dialogue occurred.

These findings would seem to be supported by findings from Norway. OD was implemented in Norway by cross-fertilising existing network-orientated approaches to mental healthcare with OD principles (Buus et al. 2017). Qualitative interviews with six young women about their OD experience some years before suggested that OD had only been positive for two of them; these two service-users recalled a dialogue having been established in the meetings, whereas the others had no such recall (Hauan, 2010 - cited in Buus et al. 2017). However, how 'dialogical' these dialogues were was not reported. Norwegian research has, however, begun to cast some light on what might be happening in OD during significant moments of change. Ropstad (2010 - cited in Buus et al., 2017) and Grosås (2010 - cited in Buus et al., 2017) respectively identified service-users and their parents' reflections on their private intrapsychic thoughts during OD. They found that inner dialogues (private intrapsychic thoughts) were more frequent during dialogical conversations than monological ones. Having video-recorded OD meetings and asked OD-users what they were thinking at significant moments of change, Lidbom, Bøe, Kristoffersen, Ulland, & Seikkula (2014, 2015) have suggested that inner dialogues broaden a person's perspective of the meaning they attribute to a topic. In a reciprocal relationship with inner dialogues, outer dialogues provide new language for inner dialogues. It is observed that this interplay seems to be related to significant moments of change in OD. Furthermore, by observing and interviewing 11 OD service-users, across 30 OD meetings, over periods ranging from 6 to 18 months, Brottveit (2013 - cited in Buus et al., 2017) identified how perspectives broadened in OD and how moments of change related to self-disclosure and conflict. Change in insight, or understanding, was not so important in OD as the change that occurred in social reality by virtue of the presence of network members and by virtue of issues being discussed emotionally, rather than representing issues but not accompanying them with their respective dynamic emotion (Brottveit, 2013 - cited in Bøe et al., 2015). It would seem, therefore, that OD users being able to open up and share their inner dialogues and having these responded to in a way that encourages this dialogue and emotional

exchange, permitting conflict as it arises, may be the benefit of OD, and may induce positive outcomes, such as symptom reduction or return to education/employment. These findings support Seikkula's (2002) finding that when dialogical dialogue occurs, positive outcomes for OD users appear to follow.

Research also suggests that, for some OD users, their uncertainties about the process of OD may not have been overcome by sufficiently positive responses. In one OD initiative in Norway, it seemed that network members were less enthusiastic about engaging in OD, possibly because of uncertainty both they and service-users had about the freedom to talk openly in meetings, as well as about what options they had in regard to participating in these meetings (Holloway, 2009 - cited in Buus et al., 2017). In Denmark, Johansen and Bille (2005 - cited in Buus et al., 2017) carried out qualitative interviews with two families who had been using OD in the community and reported that the families felt unclear about the role of the professionals in OD and about their treatment at the end of the meetings. In the USA, frustration was expressed by OD users about the uncertainty of their need for additional mental health treatment and social care, due to the ambiguity of the decision making process in OD. (Gordon et al., 2016). It is difficult to assess the value of these studies given the limited information available about their methodologies, but they do seem to raise questions as to the reliability of OD and the ability during use of OD to form dialogical dialogue. The unpredictable nature of the dialogue has been identified as particularly threatening for those suffering from trauma (Kamya and Trimble, 2002) and it has been suggested that social network members prefer monological dialogue at times of crisis because of its greater predictability. It could be that OD is inherently anxiety-provoking, but more research is needed to understand how the, relatively new, OD process is experienced by OD users.

**The Experience of Relationships in OD:** Research suggests that OD has been appraised as an acceptable approach by both service-users and family/social network members. Furthermore, it is an approach that seems to lead on to experiences of shared understanding and improved resilience to the mental illness.

Several studies, across a range of services for different service-user needs, have identified positive experiences of service-users using OD in Denmark. Based on

qualitative interviews with families who had used a child and adolescent multidisciplinary crisis team with an OD approach, Jensen and Jensen (2001 - cited in Buus et al., 2017) reported that families found this approach favourable. Based on a case study approach of two families who had used a community psychiatric OD service, OD was described by the families as respectful and involving. Looking at OD in a dual-diagnosis service with qualitative and quantitative measures, Thylstrup (2009 - cited in Buus et al., 2017) identified that the quality of relationships within families was positively affected. Improved relationships with friends were also identified as helpful for reducing social isolation. Using both observation and interviews, a case study approach was taken to explore the OD experience of users of an outreach service for people that were not in contact with mental health services. It was found that these service-users and their parents felt that they were 'seen, heard and respected' (Balleby & Søjberg, 2012; Søjberg & Balleby, 2012 – both cited in Buus et al., 2017).

Hartman and De Courcey (2015) described how OD was applied in a regional Australian city, within a child and adolescent mental health service for “complex, severe and treatment resistant problems”. A multidisciplinary team was given two days of training, followed by monthly video-supervision. These authors reported that families were accepting of OD and that they appreciated it as 'convenient and respectful'. However, these assertions were made from the anecdotal observations of the professionals, rather than using rigorous methodology designed to allow service-users to explain their own experiences.

Research using qualitative methods suggests that Norwegian OD has provided its service-users with the opportunity to improve their mental health understanding and relationships with others (Brottveit, 2002 - cited in Buus et al., 2017). This research also showed that social network members engaged more with treatment when OD was used. Qualitative interviews with five service-users on an acute inpatient ward suggested that OD may also be useful for both service-users and their families' in such settings, with family members taking on new roles in the mental healthcare approach (Settem, 2008 - cited in Buus et al., 2017). Again, the paucity of information about the methodologies used in these studies limits the extent to which their validities can be evaluated.



In the USA, using qualitative interviews, Gordon et al. (2016) found that participants and their family members appreciated the openness, transparency and the collaborative nature of the OD approach. They reported feeling cared for and they appreciated not feeling that this care was limited by time or that treatment was most focused on medication. The reflections of professionals were said to have added to the collaborative experience which service-users reported in OD meetings.

In Sweden, Piippo and Aaltonen (2009) also explored the effect and value of having relatives in OD meetings, using a grounded theory approach (Corbin and Strauss, 1990) to develop a theory about the data collected. They interviewed 10 service-users with a diagnosis of schizophrenia who had been in treatment for two years jointly with relatives with whom they had been attending OD meetings and asked them about their OD experiences. They found that involving relatives allowed for shared understanding about the service-user's situation, which led to them all feeling more able to cope and to feeling safe. The grounded theories developed above may be useful for the interpretation of other OD users' experiences, but with a degree of caution, as these theories only claim to explain the experiences of those who participated in Piippo and Aaltonen's (2009) study.

The limited amount of information about the methodologies used in these studies limits the extent to which their validities can be evaluated. Research from Norway, Denmark, Sweden, the USA and Australia, however, does seem to support the understanding of OD as an acceptable and useful approach for service-users and their families'. It may be that helpful relationships in OD were experienced by these users due to the presence of trust, honesty, respect and democratic power distribution in OD, as Piippo and Aaltonen's (2008) theory would suggest.

For the purpose of coordinating mental healthcare services and social services in Sweden, a family orientated approach inspired by OD was taken (Buus et al. 2017). Six months after commencing OD 22 service-users were interviewed about their OD experience (Piippo and Aaltonen, 2004). Using a grounded theory approach (Corbin and Strauss, 1990), four positive, two ambivalent and two negative aspects of OD were identified. The themes of trust-mistrust and honesty were integral to all aspects of these

results. Professionals trusting service-users was identified as leading to service-users trusting professionals. Involving service-users and their social network in co-ordinating treatment was also deemed important. Conversations in OD which were open and reflexive were identified as useful, with trust and honesty being essential. Piippo and Aaltonen (2008) further developed this data set by comparing it to the conventional healthcare which the participants had received prior to OD. They identified that respecting the service-user's expertise, allowing openness and having joint discussions were important in generating knowledge about the mental health issue. They found that trust increased when service-users felt more autonomous and that, in these situations, power was felt to be distributed evenly between professionals and OD users. A report of partial integration of OD principles into an acute inpatient unit for psychosis and bipolar disorder indicated that service-users were more able to trust clinicians, and, correspondingly, clinicians reported increased collaboration with service-users (Rosen and Stoklosa, 2016). One can speculate that this was due to integration into treatment discussions of the reflexivity, trust and honesty intrinsic to OD, as reported by Swedish researchers.

In the auto-ethnographic study of her experience of Finnish OD, Olsen (2015) describes OD as a humanistic and democratic approach. This description encapsulates both the quality of the relationships experienced in OD and the process by which these experiences become possible. Research has also attempted to understand users' experiences of both relationships and meaningful dialogue in OD, from an epistemological position which is consistent with OD's assumption that experience is developed via dialogue, in a particular social context. Bøe et al. (2015) took such a dialogical-phenomenological epistemological position, perspectives from dialogical philosophy, and a dialogical approach to qualitative data analysis (Sullivan, 2012). Based on interview data with adolescent service-users and their social network members, who had been using OD in Norway, a theoretical perspective was developed that interprets new meaning as forming in dialogical conversations due to the inherent ethic in such conversations of attending to and valuing others. As well as demonstrating how critical theory can be used to widen perspectives about the experiences of OD users, this research emphasises how meaningful dialogue appears to be related to respectful relationships.

In summary, the above research on the OD process suggests that supportive and helpful relationships have developed in OD between users and professionals, but also between users. It suggests that OD may have applicability across mental health services, but that more research is necessary to achieve more comprehensive understanding of the implications of OD in these different contexts for its users, and how the process of dialogue plays a part in this experience. The small number of studies available and the limited amount of information available about their methodologies, limits what can validly be said about the experiences of those who have participated in them. The qualitative methodologies used and, in one study the anecdotal approach used, limits consideration about what this research might mean about other OD users, to speculation.

### **Rationale**

I did not find any research on the experiences of OD users in the UK. Research has shown, however, that both NHS service-users and staff support the idea that OD could be useful in the NHS (Razzaque and Wood, 2015). It is anticipated that a national randomised-control trial of peer-supported OD across five NHS trusts in England will commence in 2017 (Pilling, 2016). Seikkula and Arnkil (2014) argue, however, that randomised-control trials are often deemed to be the gold standard of mental health research, to the detriment of producing more useful idiographic knowledge. Research that helps to describe OD in local contexts, they argue, can be more useful for practitioners developing OD services than randomised-control trials. These authors argue that descriptive knowledge about a locality helps those who act within it to understand it more than explanatory, simplified and context-independent knowledge. By producing idiographic knowledge about families' experiences of NHS OD, I hope to contribute to the gap in the literature about this topic, which I hope will raise further research questions that may need to be considered during the ongoing use and development of NHS OD. Feedback from a psychiatrist who presented my initial research proposal at the International Society for Psychological and Social Approaches to Psychosis Conference, in 2015, in New York, emphasised psychologists' interest in how service-users value their OD experience and what the factors affecting them

through this experience are. I hope that the focus I have chosen for this research will provide a response of value to the inquiries of these professionals.

## **Chapter 2: Methodology**

### **Overview**

In this chapter I will state the aims of this research and describe how I decided upon my methodological approach. I will include my epistemological position, the methods I used, methodological reflexivity, the ethics permissions I needed and the ethical issues I considered.

### **Aims**

I aimed to answer the following research question: ‘How do families experience OD in the NHS?’ I wished to develop a descriptive, rather than an explanatory understanding of the lived experience of OD, via analysis of each families’ co-constructed narrative of their experience. I wanted to explore how these narratives might be further understood from the perspective of critical social theory. I hoped to include analysis of participants’ experiences, since they had started using OD, of their relationships with each other and with professionals, as well as of how they have understood mental illness.

### **Qualitative Research**

Qualitative research aims to describe the quality of experience and can be used to analyse the meaning in participants’ subjective experiences (Willig, 2013). It approaches research with an idiographic rather than nomothetic aim, exploring experience rather than testing or predicting it (Willig, 2013). Qualitative methodology was, therefore, most appropriate to the idiographic aim of this research of describing families’ experiences, rather than trying to explain it.

### **Epistemology**

“Epistemology is a branch of philosophy concerned with the theory of knowledge. It attempts to provide answers to the question, ‘How, and what, can we know?’” (Willig, 2013). In order to further define the kind of knowledge I was hoping to generate I describe my epistemological position. This position was based on the ontological assumption that reality is, at least partially, determined in dialogue. The social structures, like families or healthcare services, which form these contexts were assumed to exist beyond these dialogues. In these contexts, I did not assume that there is an

absolute truth to be found, but, instead, I assumed that many subjective truths are possible, due to the polyphony of possible voices in any one dialogue, as described by Bakhtin (1984). In accordance with this, I took a contextual constructionist epistemological stance (Lyons, 2007), which assumes that “all knowledge is context specific and influenced by the perspective of the perceiver.” I assumed that participant experience would, at least partially, have been determined in dialogue and that it would be relative to the particular social context of each dialogue. I considered that the existence of social structures like healthcare systems, social networks, or particular mental illness narratives might affect how participants socially construct their experience. Since I was interested in how wider discourses may affect how a person can construct their experience, rather than just how they construct themselves in a situation, my epistemology can be described as moderately, rather than radically, socially constructionist (Willig, 2013). Rather than just being interested in how available discourses could influence what the individual could say about themselves, I was interested in how an individual’s social context affects their lived experience. As well, therefore, as a moderately socially constructionist component, my epistemological position included a phenomenological lens (Willig, 2013). I took the position that, as well as families’ experiences being context specific, so would my perceptions of these and, therefore, I would need to help the reader understand my subjective position as a researcher.

Within the human sciences, discursive epistemology, the focus on what can be learnt by considering the language used and its context, has been criticised for being too radically social constructionist; Augoustinos and Walker (1995) essentially contend that discursive epistemology circumvents the possibility that subjective experience may not be absolutely context dependent. Crossley (2007) argues, therefore, that contemporary psychology needs narrative psychology to bridge the contextual social constructionist understanding of experience and identity, with that of “the essentially personal, coherent and ‘real’ nature of individual subjectivity.”

### **Narrative Psychology**

Arguably since the 1960s, but more prominently since the mid-1980s, Riessman (2008) describes how there has been a cross-disciplinary move away from realist or positivist

epistemology, towards narrative epistemologies. Essentially, narrative psychology takes the stance that by considering the narratives people tell and the context in which they tell them, one can develop understanding about their experiences, behaviours or identities. Within psychology, the case-study narrative approach stems from psychodynamic approaches to understanding people via their narratives, pioneered by Freud (Hiles and Cermák, 2008). Ricoeur (1984) argues that narratives help people order their chaotic worlds. Murray (2003) describes how narrative offers people a way of dynamically defining who they are and who they have been, both for their own self-identification and for the purpose of illustrating this to others. Polkinghorne (1988) explains how narrative can be a way of integrating the things that have happened in a person's life. It seemed to me, therefore, that exploring narratives could not only tell me about what has happened to a person in their particular context, but also how they identified themselves and their experience within this. It also seemed credible that the stories people narrate are dependent on the narratives available to them (Bakhtin, 1984; Frank, 2012). As well, then, as human experience shaping narratives (Ricoeur, 1984; Murray, 2003; Polkinghorne, 1988), I agreed with Hiles and Cermák (2008) that narratives play a key role in structuring human experience. The particular utility of narrative psychology for this research was, therefore, how it allowed for consideration of human experience in relation to social context via narrative. The socially contextualised nature of narrative also means that individual experiences can be rendered in narrative as part of "a shared version of reality" (Hiles and Cermák, 2008). Narratives, therefore, offer an opportunity to understand the experience of individuals and groups in relation to their social context. Given the understanding that narrative can offer about the human mind, Hiles and Cermák (2008) argue that using it as a research methodology could be very helpful for psychological research. It seemed that focusing on families' co-constructed narratives would be a methodological approach that would be consistent with my research aims and epistemological position.

## **Methods**

### **Participant Recruitment**

Since a London NHS trust were working on the OD trial, it made sense to use a convenience sampling strategy. This trust agreed to collaborate with me to try and recruit participants for this research.

**Inclusion Criteria:** Service-users needed to be suffering from SMI and to currently be using a CRHT or a CMHT. I was told by an NHS clinical psychologist that it would be likely that the service-users would either have had at least one past psychiatric hospital admission, or/and more than 6 months of community psychiatric care, although this was not a stipulated inclusion factor. Given the inclusion criteria of these services, all service-users would be aged between 18 and 65 years old. Their relatives could have been of any age. The sex and ethnicity of all participants was not a determining factor in recruitment.

All participants had to be thought to have the mental capacity, according to the Mental Capacity Act ("Mental Capacity Act", 2005), to decide to participate. They must have been judged to have this mental capacity by their care coordinator.

**Exclusion Criteria:** I did not ask service-users who were still acutely unwell to participate. This was because their illness may not have been managed safely enough, given my limited resources as a researcher and the high risk these service-users may have posed. The interview could also have been distressing for an acutely unwell service user. Service-users were judged to be acutely unwell if, in the opinion of their care-coordinator, they were deemed too high risk or too disorientated to participate. They would be deemed suitable for CRHT treatment or treatment by inpatient services. 'Rethink Mental Illness' ("Crisis Teams – About", n.d.) defines CRHT as for people considering suicide, those who have lost touch with reality and for those who are putting others at risk. If a person poses these risks and there is no safe way of assessing or treating them at their home, then they may be admitted to hospital ("Could I get care in hospital?", n.d.).

Due to the expected difficulty in interviewing service-users in a group interview with an interpreter, participants who did not speak fluent English were not asked to participate.

**The Recruitment Process:** The recruitment plan was for a psychiatrist, or his colleagues, to offer their OD users a leaflet about the study (Appendix 1), along with a brief explanation of what it was about, and to ask the users to inform them if they were interested in participating. An information poster (Appendix 2) and some leaflets were



also left in community mental health team reception areas. Having not heard from any interested service-users, I decided to attend some community mental health team professional meetings in order to discuss the research with clinicians. I found that most clinicians did not fully understand my research. After discussing it with them, however, they reported being much clearer about it. Feedback from a professional in one of the professionals' meetings I attended led me to distribute the one-page study advert (Appendix 2) to clinicians, so that they could offer this to service-users instead of the more complex study information leaflet, as the leaflet was felt to be too complex for some service-users. This strategy of clarifying the research with clinicians resulted in families participating. I was given the telephone number of the family member who had given permission for me to call them. I then called this person to assess the suitability of their family to participate in this research.

When I telephoned the family member who had agreed for me to call him/her, I asked him/her if he/she had any questions about the research and their possible involvement in it. If they were interested in participating, I then arranged a meeting with the family, either at their home or at community mental health team offices, according to their preference. Participants were informed that this meeting would be an opportunity to ask any other questions about the research and, if they wanted to participate, to sign consent forms and to be interviewed there and then. I then posted them copies of the participant information sheet, which detailed more of what would be involved in participating in the research (Appendix 3). When we met, we discussed any other queries about participating and, then, if they were happy to participate, I asked each family member to sign a consent to participate form (Appendix 4). All the participants I met consented to participate and wished to be interviewed at that time.

### Sample

Five families were recruited from a CMHT. See Table 2 for an outline of each family's demographics. All other identifiable participant characteristics have been withheld to maintain anonymity. The participant names used in this report are pseudonyms.

<b>Families</b>	<b>Ethnicity</b>	<b>Age</b>	<b>Service-User</b>	<b>Diagnosis/es, as reported by participants</b>
<b>1) Mary and George</b>	Both White-British	49, 52	Mary	Bipolar Disorder
<b>2) Laura, Vivienne and Jerry</b>	All White-British	35, 64, 64	Laura	Bipolar Disorder
<b>3) Dave and Sharon</b>	Both White-British	47, 68	Dave	Generalised Anxiety Disorder and Depression.
<b>4) Sheila and James</b>	Both White-British	28, 27	Sheila	Schizophrenia
<b>5) Alfred and Jennifer</b>	Both White-British	21, 50	Alfred	Asperger's Syndrome, Depression, and Social Phobia.

**Table 2: Participant Demographics**

### Informed Consent

As well as the research information leaflet that participants were originally given by their OD clinician (appendix 1), and any information their clinician told them about the study, participants had two opportunities to ask me questions about the study before deciding to participate: when I spoke to the member of the family who had agreed to talk to me on the phone initially, to assess their family's suitability for participating, and when I met with them to discuss this again. I posted suitable participants the more detailed research information sheets (Appendix 3), which included: a statement about how their identity and information would be kept anonymous, information about how their data would be stored and for how long, and a statement about how they had the right to withdraw at any time. When I met them at the location of their choice, I asked them if they had received this and if they had any further questions about the study. I reminded

participants that, if concerns were raised in the interview about their safety, or anyone else's safety, that I would endeavour to talk to them about these and that I may need to inform their care-coordinator about these concerns. If they were still willing to participate in the study, then I asked each family member to read and sign a consent to participate form (Appendix 4).

### Interview Design

**Pilot Group Interview:** Given my limited research experience and the potential vulnerability of my sample, I chose to organise a pilot group interview, in order to help determine the validity of this data-collection method for my research aims. I wanted to learn about the experience of being an interviewer and an interviewee in a group interview. I wanted to develop skills in using a semi-structured interview schedule, seeking clarification and encouraging circularity (contributions from less dominant participants).

The participants of the pilot were three colleagues of mine from the Professional Doctorate in Counselling Psychology at City University of London. In an interview that lasted one hour, I asked the participants about their experiences of their counselling psychology training. I found that I did not have time to ask all the questions intended. I asked three of eight principle questions and some of the sub-questions (see Appendix 5 for the pilot interview schedule). I deduced, therefore, that, with 90 minutes, I would have time for five principle questions. In order to allow participants as much authorship of their experience as possible, I decided that I would ask each principle question and then, after participants had answered this question, I would check if participants had anything else to add with sub-questions, before moving on to the next principle question. I also developed skills in seeking clarification of participants' answers.

**Interview Schedule:** Although I had been interested in using a narrative form of enquiry, I was unsure whether I would collect narrative data due to the vulnerabilities of my sample and the group interview approach. Indeed Riessman (2008) explains how trauma can limit a person's ability to narrate, Kitzinger (1994) suggests that dominant group norms may silence individuals who would otherwise dissent from this norm, and Marian (2010\*) suggests that people may not wish to discuss their experiences with relatives

who may have played a part in their traumatic history. I wondered, therefore, whether the family interview approach I wanted to take might hinder the co-construction of narratives. I was also unsure about whether participants' discussions of their experiences would include reflection on my particular interests. I, therefore, decided that a semi-structured interview (Appendix 6) could help me to achieve my research aims and that it might help facilitate the co-construction of narratives of experience. The questions I decided to ask were influenced by the following interests I had:

*Meaningful Relationships:* I was interested in participants' reflections on what it had been like to talk about mental health issues as a family, both in and in-between meetings. I was concerned, however, about focusing on family relationship dynamics due to the possibility of traumatic relationship histories (Marian, 2010\*). I thought that such family dynamics might be a very sensitive topic of conversation that might result in significant distress to participants. Rather, therefore, than asking about any relationships in particular, I thought it best to ask more generally about recent experiences of family relationships, as well as about related experiences of expressing oneself and being listened to by relatives. Given the value OD placed on continuous relationships with professionals and the apparent fundamental importance of the therapeutic relationship to effective psychotherapy (Norcross, 2011), I was also interested in how participants experienced their relationships with mental health professionals. As well as including general questions about experiences of being listened to and expressing one's self in OD meeting, I, therefore, added a general question about participants' experiences of OD professionals to the interview schedule.

*The Understanding of Mental Illness:* I was particularly interested in the experience OD users had of developing understanding about their mental health concerns. As well as asking participants directly about any experience of this, I asked participants to think about moments of significant change in their mental health understanding since commencing OD. The critical incident technique (Flanagan, 1954), developed for psychotherapy evaluation research, asks participants to reflect on significant moments of change. Rather than using this question to give participants an opportunity to evaluate OD, however, I hoped that this adapted version of the critical incident

technique might help participants to discuss any experiences they may have had of developing understanding about their mental health concerns in OD.

Furthermore, in order to help families to co-construct their narratives of experiences, I used 'circular questions', as used in systemic psychotherapy (Pote et al. 2001). Circular questions encourage participants to consider each other's perspectives and can encourage new information into the discussion. To encourage less dominant participants to contribute to the interviews, it seemed that using questions such as "Do you agree with what [relative's name] has said about this?" may be useful. I used circular questions to give less dominant participants more opportunity to contribute to the interview where I deemed it appropriate. In order to ensure that I clearly understood participants' descriptions, I realised that I would also need to be clear about how I could seek clarification within the interview. I, therefore, decided upon some quick and simple questions I could ask to seek clarification. I integrated some clarification prompts into my interview schedule, as suggested by Krueger's (2000) guide to running group interviews. One example of this was "Can you explain what you mean by [aspect of participant answer]?"

In summary, I was interested in exploring participants' experiences of the processes that OD advocates, such as listening and responding carefully, allowing understanding about the mental health issue to develop without having to abide by a meeting agenda, and continuous relationships with mental health professionals. I was not aiming to evaluate OD. I was aiming to ask participants questions about their experiences that were influenced by and relevant to the processes that OD advocates as therapeutic. I designed my interview schedule upon two key principles: 1) Non-leading and open questions, so as not to predispose any experiences I might be told about and 2) A schedule with broad and open questions, with enquiries into how participants' experience had been over time, to provide an open space in which participants might feel able to tell me their stories' of OD.

### The Interview Process

Each family of participants was asked to attend a group interview, consisting of that family of OD service-users only, to talk with me about their experience of being an OD

service-user. I asked each family whether they would prefer to have the interview at their home or at an NHS community mental health team clinic. Families 1, 2 and 5 (see Table 1) invited me to interview them in their homes. Families 3 and 4 (see Table 1) requested to be interviewed at a clinic.

My safety was also considered. I informed each family's care-coordinator in the participants' community mental health team where and when I would be interviewing participants, and how I would contact them in case of emergency. I arranged to call them after the scheduled interview end time to inform them about my welfare. I arranged for them to call me if I did not call them and for them to inform their colleagues if they had any concerns about my welfare.

The following interview procedure was then used:

1. Participants were asked to sit around in a circle with the interviewer.
2. They were given the opportunity to have any further queries answered that they may have had about the research.
3. Participants were reminded that the group interview could last up to 1.5 hours.
4. The digital audio recorder was then turned on.
5. I asked participants for their age and ethnicity information.
6. The semi-structured interview schedule (Appendix 6) was then used to interview each family.

**Amendments to This Procedure:** In order to suit the particular wishes of each family and my research aims, I tailored this interview procedure in the following ways:

*Usage of Interview Schedule:* Upon reflection, after the first family interview, I realised that much of my interview schedule had been covered by the family's answer to my first question, in which I broadly asked them what their experience of OD had been like. Half-way through the interview, I checked my interview schedule to see which points had already been covered and then I proceeded to ask this family other questions from my schedule. It seemed that I would play a less disruptive role in participants' constructions of their narratives if I were to ask less questions, whilst checking my interview schedule to see if any areas had not been discussed. I, therefore, decided that, for the subsequent

interviews, that I would open the interview with question one and only ask other questions if it seemed that families were not discussing these topics of their own accord. The questions I asked in each interview can be viewed in Appendix 7. I found that the process of my interview schedule varied from interview to interview, but, in no interview, did I need to use all of the schedule and, in all interviews, my key areas of interest were discussed. I was hoping for the interviews to be, mostly, an opportunity for interviewees to co-construct the narratives of their experiences with each other, rather than for participants to feel that they were being interrogated by an interviewer (Kvale, 1996). Ultimately, as an interviewer, I would play some part in how the narratives were co-constructed (Mishler, 1986), but I wanted to minimise the extent to which I did.

*Keeping on Topic:* Some families tended to talk a lot about their care prior to OD. Although it was useful for me to understand the context of their OD experience, I wanted the interview to focus on their OD experience. I was, therefore, mindful in all interviews about checking with participants whether the experiences they were telling me about were OD experiences. Generally, I would allow participants to give me an outline of a non-OD experience and then clarify with them how it related to their OD experience. Where discussing a non-OD experience seemed important for contextualising an OD experience, or, in other words, for telling me the story of their OD experience, I would allow participants to continue telling me more about this.

*Interview Time:* Although the first family interview had finished within about 90 minutes, the second family said that they were comfortable with carrying on the interview beyond this time (140 minutes in total). Thereafter, at 90 minutes, I checked with each family to see if they wished to stop there and, if not, whether they felt comfortable carrying on, given that we had already been talking for a long time about a personal topic. It became apparent that 90 minutes was not long enough for all families. With the subsequent families whom I interviewed, I advised them before commencing the interview that they might want to take longer than 90 minutes to tell me about their experiences, and that I would be happy to offer them extra time if they wanted it. I checked with participants how they felt about ending the interview at the 90 minute point, as in the first two interviews: the longest of these latter interviews was 102 minutes.

*Broadening my Critical Enquiry:* Upon reflection after my third interview, I observed that, although participants had not been entirely positive in their descriptions of their experience of OD, the experiences that had been portrayed appeared to be generally in praise of the approach. I considered whether my interview schedule could have discouraged participants from expressing more critical experiences of OD. I, therefore, decided to add the following question to the subsequent interviews: “Is there anything that could have been more helpful in your OD experience?” I thought that this may open an opportunity for interviewees to share more critical aspects of their experience of OD. I found, however, that when I asked this question, none of the participants had anything additional to add about their OD experience.

### Debrief

Since the subject matter of this research was of a highly sensitive nature, I considered it possible that the interview might lead to participants experiencing distressing feelings. Each group interview was, therefore, offered a debrief session for up to one hour with myself. The service-user who had been experiencing SMI was also offered an additional one-to-one debrief session with me. Although I gave them the option, I was aware that participants might not want a debrief session with me straight after the interview, so I told them that this could be arranged at a time that would be convenient for them. I informed them that any unsettled feelings that may have been evoked could be discussed in this session, along with reflections on how the group interview was for each member in general. If both a group and individual debrief session were required by a family, I decided that I would ask the family which debrief session they thought would be best organised first, but that I would also use my judgement to consider whether the needs of the individual or group required more immediate support. Should any concerns have persisted beyond this debrief session, I would discuss with participants whether it might be a good idea to inform their OD clinicians about these. If I decided it was necessary, I would then inform the respective clinicians about my concerns. I offered to post a copy of the research results to all participants upon completion, which all participants requested. Each participant was given a copy of the debrief information sheet (Appendix 8) to summarise the background, aims, rationale and next steps of the research. Since the completion date of the research was delayed, I wrote to participants



in April 2017 to explain this to them and to remind them that I would make contact with them again, once I have the results ready to share with them.

### Storing and Transcribing Data

Participant data was stored on my password-protected computer and backed-up on my external hard-drive with password protection, both of which were kept at my home. Any data that I shared with my research supervisor had all identifying data removed, including names, which were replaced by pseudonyms. Participants were informed before agreeing to participate that their data would be stored for up to 5 years in order to publish the findings.

I employed two professional administrators to transcribe the interview recordings. They both signed a confidentiality agreement (Appendix 9), stating that they would not disclose to anyone the content of the interviews or any information about the participants. Participants were informed about the transcription and storage procedures of the research before they consented to participate.

### Analysis

**Methods of Analysis Considered:** Originally, I had been interested in exploring participant experience as it is co-constructed in narratives with relatives. The examples of this that I found, however, did not seem applicable to the aims of this research (e.g. Gallas 1994; Brown 1998). Thematic analysis (Braun & Clarke, 2006) offered a structured way of interviewing groups. Initially, I had considered looking for themes of experience across family interviews with a constructionist thematic analysis (Braun & Clarke, 2006). I realised, however, that this would lead me to grouping participant experiences together across families, rather than analysing the experiences of each individual family, and that this would have detracted from my aims. Having completed a trial thematic analysis of my data, it seemed that the individual narratives that constituted the themes had got lost in this analysis. Although I had been uncertain if narratives would form in my group interviews, it seemed clear to me then that they had. I, then, considered using Frank's (2010; 2012) dialogical narrative analysis. It seemed that this could be used to think about the stories being told by a family and how these stories positioned the storytellers. This approach had, however, been developed from sociological and literary

schools of thought and I realised that its focus was more on the function of narratives than the experience of people.

Upon it seeming clear to me that narratives of experience had been co-constructed by families, I continued my search for a suitable narrative method. Having learnt about the plethora of narrative methods available for psychological research by reading Riessman's (2008) guide on the topic, it seemed that considering the narrative content, structure and the social context in which a narrative is formed via dialogue could help me achieve my research aims. I was still unclear, however, which particular narrative methods and in what combination would be most useful for the purposes of this particular study. Riessman (2008) highlights how narrative methods are often tailored to the particular aims and contexts of a research study. Not having found a study that had a similar context or set of aims to my research, nor having had much experience in implementing qualitative research, I was keen to find a framework, or model, that would help me to think about how I could use narrative methods in my research. Narrative Oriented Inquiry Hiles and Cermák (2008) offered a pluralistic framework for rigorous narrative research, which integrated both social constructionist and phenomenological perspectives. Along with researcher reflexivity, the framework includes taking macro and micro perspectives of both the form and content of a narrative. I was not sure how I could use this framework, however, to choose the narrative methods that would be most suitable for my research.

Critical narrative analysis (CNA) (Langdridge, 2007) provided a relatively clear set of methods for analysing aspects of narrative content and form, in relation to the social contexts of narratives, with the inclusion of critical social theory to further understand these contexts and the subjectivity of the researcher. Having read Langdridge's (2007) worked example of CNA, it was clear to me how this method could be used to explore aspects of participant experience, via analysis of their narratives, and how these methods could be tailored to the individual study. The inclusion of critical social theory seemed useful in helping me identify my subjective position as a researcher and the contextual factors that might be affecting how participants constructed their experience via narrative. Critical narrative analysis was also consistent with my epistemology. This, along with its flexibility about how it could be tailored to suit the particular aims and

context of a research project, made me believe that I could adopt and adapt this analytical method to achieve my research aims.

**Critical Narrative Analysis:** It seemed that I could adapt Langdridge's (2007) CNA to suit my research aims. In order to interpret a text with full understanding, Ricoeur (1970) argues that in order to understand the participant, both 'hermeneutics of empathy', and 'hermeneutics of suspicion', like psychoanalysis, that digs for hidden truth beneath what is initially apparent, are needed. Langdridge (2007) bases CNA on Ricoeur's (1970) work, but rather than advocating a hermeneutic of suspicion and digging for the truth as outlined above, he suggests using critical theory to open up other possible interpretations of a text, to enable "a critical analysis of the narrative world that both allows and limits the person's ways of speaking about his or her world." Given my contextual constructionist epistemology and research aims, the opportunity to explore the narrative world of the participants from a critical narrative perspective was appealing. Both the idiographic approach to knowledge generation of CNA and the capacity of the method to develop understanding about group narratives (Langdridge, 2007), suited my research aims.

Langdridge (2007) argues that CNA is intensive and that, due to practical restrictions, as well as the differing aims of research projects, the methods involved in CNA may need to be tailored to suit these factors. Langdridge (2007) states that stages 2-4 of CNA alone can be used to produce rigorous research. Stage 1 (critiquing my subjectivity as a researcher with critical social theory) and stage 5 (critiquing the data with critical social theory), seemed useful, however, given my epistemology and research aims. Below, I outline the methods of CNA and describe the way that I utilised them to suit these purposes and my theoretical positioning. For a full description of CNA the reader can refer to Langdridge (2007). Having already completed a Thematic Analysis (Braun and Clark, 2006) of the data, I was already very familiar with it. I intended, however, to approach the data afresh, using the methods below.

*Stage 1 - Critique of the Illusions of my Subjectivity:* Langdridge (2007) argues that by first identifying one's subjective responses to a text and then viewing this through the lens of critical social theory, a researcher can enable a "perspectival shift", a stronger

identification of their subjective position and, therefore, less of a likelihood of subsuming the participant's meaning to the subjective judgement of the researcher.

In order to open up reflection on my subjectivity in relation to this research, I first read through the transcripts to re-familiarise myself with their content. From this reading I recognised how pleased I was that participants generally seemed to be describing an experience of empowerment in OD. I, then, reflected on the origins of my interests in OD and this project (see 'personal reflexivity statement' in preceding chapter). I considered how these experiences and viewpoints had evolved into the aims of this research. To further open up this subjectivity, I used Langdridge's (2007) reflexive interview. Applying Foucault's (1988) critique of the power that institutions have over the meaning of "madness" to my own perceptions on this matter, I questioned my preconceptions about families' experience of OD. Having identified that I had had a very similar reaction to all the interviews, it made sense to focus on critiquing this subjective response and to apply the, hopefully, resultant broader analytical perspective to stages 2-5 for each family interview.

*Stage 2 - Identifying Key Narratives, Narrative Tone and Narrative Function, and Stage 3: Identity Formation:* Langdridge (2007) suggests that these stages are significantly interlinked. It made sense to me to think about stage 3 in relation to stage 2. I began stage 2 by reading through each family's interview transcript to try and identify the narratives being portrayed by participants about their experience of OD. Every time I identified a key narrative, I, then, considered the tone and function of this narrative, as well as the identity work being done by it. After completing this process, I, then, considered all the key narratives I had identified from a macro perspective, to decide upon the master narrative that was apparent to me.

- As suggested by Langdridge (2007), I looked for particular changes in content or characters being discussed to help me identify new narratives.
- To aide my identification of narrative tone, I used the audio recording of the interview and, as per Langdridge's (2007) suggestion, I chose to describe the tone in the way that seemed most appropriate to me. Other aides I used to help me

identify tone were looking for apparent changes in tone, as well as rhetorical devices such as excuses, justifications and criticisms, as suggested by Langdridge (2007).

- To help me think about the function of a narrative or what it appears to be doing, I focused on considering what argument the narrative seemed to be making and of what it was trying to persuade me (Billig, 1997). I, also, considered what the narrative seems to be a response to, taking Bakhtin's (1984) assumption that talk occurs in a dialogical context. Langdridge (2007) summarises this perspective: all talk is "always a response to other talk". I looked at how the narrative might be justifying a position and, possibly, criticising another. I considered whether the function of the narrative appeared to change. I considered how my presence and the presence of family members in the interviews may have played a role in the co-construction of narratives, and, thus, how each narrative was functioning.
- In regard to the identity formation work being done by a narrative, I decided to focus this aspect of narrative analysis on the service-user who had a diagnosis of SMI. If I had had more time, I would have been interested in analysing other identity formations in the narratives as well.

*Stage 4 - Thematic Priorities and Relationships:* Rather than breaking down the text into codes and generating themes from these codes alone, Langdridge (2007) describes how themes should be identified from codes by keeping in mind the narrative being told in the text. By doing this, whilst identifying key ideas and cyclically returning to the text, Langdridge (2007) recommends clustering ideas into themes and sub-themes. Maintaining this cyclical process, he, then, suggests consideration of how these themes relate to each other. I used van Manen's (1990) guide to hermeneutic phenomenological research to help me identify key ideas within the texts, particularly his 'selective reading approach': I considered what statement would succinctly capture the particular participant experience being described. I, then, noted these ideas in a separate Microsoft Word document (see Appendix 10 for an example of this). Once completed for the whole interview, I, then, worked on clustering these ideas into themes, deciding which were substantial enough to stand out as themes and which needed collapsing into

themes to become sub-themes. I continued to remind myself of the key narratives and master narratives I had identified for each interview throughout this process. Finally, by iteratively reminding myself of the family's master narrative, I considered how the themes might relate to each other and, therefore, in what order to present them.

*Stage 5 - Destabilising the Narrative:* Following stages 1-4, I, then, engaged a more suspicious hermeneutic to critically analyse each interview further. Langdridge (2007) argues that this hermeneutic should be imaginative: rather than aiming to reveal latent meaning, he suggests it should allow the researcher to become more imaginative about the possible interpretations of a narrative. Due to its relevance to this research, I chose to focus on using the following hermeneutic of suspicion to expand my interpretation of each text: Foucault's (1988) argument that healthcare institutions can powerfully influence the way that mental health is experienced.

*Stage 6 - Analytical Synthesis:* I decided to present the analysis of each family interview independently from one another in order to respect the individual experiences and social context of each family, as is consistent with the idiographic approach of CNA (Langdridge, 2007). Whilst identifying the key narratives that each family seemed to be co-constructing, I noticed how families presented these in a piecemeal and only partially sequential manner. By cyclically returning to the interview text, and by keeping each family's key narratives and master narrative in mind, I realised how the narrative themes I had identified could be used to order each family's journey through OD chronologically. Langdridge (2007) justifies adaptations of CNA that aid the construction of knowledge, such as this. In order to avoid overly subjecting the participants' narratives to my critical social perspective, I present then stage 5 of my analysis separately, as is suggested by Langdridge (2007). Given the breadth of my findings, I planned to synthesise them further in the discussion chapter.

### **Personal Reflexivity**

Kasket (2012) explains that counselling psychology research values offering new knowledge on a tentative basis in order to respect the uniqueness of participants, which she says involves researchers bracketing off their presumptions, or in other words being critical about our perceptions as researchers. Given the position in relation to OD that I

identified in my personal reflexivity statement, it was important for me to continually reflect on my role within the research and how it might have affected the research. Part of the appeal of CNA was that it included a further critical analysis of my subjectivity, which I hoped would help me identify my presumptions more clearly. I also used a reflective journal to help me to think about methodological dilemmas and my personal responses to the research process. This helped me to become clearer about the reasons behind my choices, so that I could present these to the reader.

## **Ethics**

I used the British Psychological Society's Code of Human Research Ethics (2014) to guide my moral reasoning about issues related to this research. It defines ethical research conduct as "the application of informed moral reasoning, founded on a set of moral principles". I used the principles it suggests to inform my moral reasoning. These were:

- Respect for the autonomy, privacy, and dignity of individuals and communities.
- Scientific integrity.
- Social responsibility.
- Maximising benefit and minimising harm.

Ethics approval was sought from City, University of London and because I hoped to do research within the NHS, it was also sought from the National Research Ethics Service (NRES). Ethics approval was granted by City University London, Psychology Department Research Ethics Committee in March 2015 (Appendix 11). Minor amendments and clarifications were requested by NRES and I, subsequently, made changes to the research proposal. In June 2015, ethics approval was also granted by South East Coast-Surrey Research Ethics Committee (Appendix 12). I, then, made several further minor amendments and clarifications, which were approved by my research supervisor at City, University of London. My supervisor and I agreed that, according to NRES guidance (NRES, 2014), these did not require further approval from NRES. I was given permission by a London NHS Trust's Research and Development department to recruit participants from community mental health teams. City, University of London and the London NHS trust from which I recruited participants had scrutinised my enhanced Disclosure and Barring Service certificate to assess the check that had been done on my criminal history.

Based on this, both these bodies had decided that I did not pose a risk to vulnerable people and that I could, therefore, work with them. When working with a vulnerable population, such a check is advised by the British Psychological Society's Code of Human Research Ethics (2014).

The British Psychological Society's Code of Human Research Ethics (2014) states that special considerations need to be given to participant populations deemed to be vulnerable, such as those with communication difficulties and those in care. Given the mental health difficulties of my sample, I considered these special considerations were necessary for my research. I used the code's suggestions of important factors to help me think about how to do ethical research with a vulnerable population.

Although this research may benefit service-users who lack the capacity to make decisions for themselves, the aims of this research were not directly focused on benefitting such people. I did not, therefore, believe I would be justified in asking such a service-user's legally responsible proxy for permission for them to participate in the study. Instead, I checked with the care co-ordinator for each family whether they judged the service-user with SMI to have the capacity to decide for themselves whether to participate in the study, in accordance with the Mental Capacity Act 2005. Hence, the participant exclusion criterion of service-users without this capacity.

I wanted to maximise the capabilities a service-user might have to make an informed decision about whether to participate in the research. I did this by offering a range of information sources and opportunities to seek clarification about the research, as detailed in the methods section. I took the time to ensure that each family member fully understood the implications of participating by checking that they had read and understood the detailed participant information sheets provided. The ethics code described above also emphasises the care that must be taken when working with 'individuals in a dependent or unequal relationship', such as service-users. As well as consent from them, it says that consent should be sought from the gatekeepers to these participants. By ensuring that OD clinicians were well informed about my research, I was able to ensure that they could give me informed consent to advertise my study to their service-users.



By offering a range of debrief options, I hoped to ensure that participants felt they had an appropriate opportunity to express any concerns they may have had after participating. None of the participants requested a debrief session with me and there were no concerns raised by clinicians about the interviews. It was my understanding, therefore, that no harm was done to the participants of this research as a result of them participating in it.

As well as the use of pseudonyms in this research report, I have not included full transcripts in the appendix, and have excluded any identifying characteristics of the participants in order to preserve participant anonymity.

### **Validity**

Yardley (2000) argues that the pluralistic and relativistic nature of qualitative approaches means that it is not appropriate to judge qualitative studies by exactly the same standards as positivist research might be judged. She suggests, instead, that a qualitative study ought to be validated according to its particular purpose within its particular context. I decided that I would judge the validity of my research according to the standards Yardley (2000) sets for qualitative research: sensitivity to the context of the research, the commitment of the researcher, the rigour, transparency and coherence of the research, and the impact and importance of the work. By including a personal reflexivity statement before the introduction, I hope I have demonstrated my sensitivity and commitment to this research. I wanted the reader to understand how my methods and interpretation led me to co-construct the narratives presented in my analysis from the participant interview data. By leading the reader through my analytical process with researcher reflexivity, and by grounding my analysis in relevant extracts from the interview transcripts, as suggested by Polkinghorne (2007), I hope that my interpretations will be deemed valid by the reader. I aimed to reflect on the impact and importance of the work in the discussion chapter.

### **Chapter 3: Analysis**

#### **Stage 1: Critique of the Illusions of my Subjectivity**

Gutting (2010) explains how Foucault (1988) argued that, unlike the attempts of previous centuries to understand “madness” as a kind of human experience, the eighteenth century saw the medical profession class “madness” objectively as mental illness, something that needed curing. Khalfa (2009) explains how Foucault (1988) argues that the psychiatric treatment of mental illness in hospitals was as uncompassionate, controlling and socially rejecting as the prior treatments of “madness” had been. Khalfa (2009) summarises Foucault’s (1988) key point: “the idea is that specific structures of power determine this experience [“madness”] differently at different moments.” Foucault’s (1988) thesis helped me to identify my assumption that participants would have felt disempowered in their mental health recovery prior to OD. Due to my professional and personal experience of mental health services (see reflection in Aims and Objectives section), it was my assumption that participants would have felt frustrated and let-down by their prior mental healthcare. I realised that in order not to become part of another powerful institution that determines service-users’ experiences, I would have to be mindful of my assumption and be open in my analysis to positive prior care experiences, negative experiences of OD, as well as possible experiences of disempowerment in prior care and relative empowerment in OD.

From the reflection I had done prior to analysis, when forming my research aims and objectives (see Aim and Objectives section), I was already somewhat aware of my critical perspective on NHS mental healthcare for severe mental illness. To maintain a reflective role as a researcher I balanced my perspective with critical viewpoints on OD. I also committed myself to working independently from the OD professionals, who may have invested in the success of OD. My interests in participants’ experiences of communication, relationships and understanding mental health had shaped my interview schedule. I designed these questions (see Appendix 6) so that they were open and not leading. After the first two interviews, I reflected on whether my interview questions were inviting participants to talk about all aspects of their OD experience. Although my questions were open, I wondered whether including a question about

whether OD could have been more helpful in anyway, would elicit other critical viewpoints. I, therefore, decided to ask this question in subsequent interviews.

### **Overview of how Analysis Stages 2-6 are Presented**

Below, I present an integrated analysis of stages 2-4 for each family, I then present stage 5 as a separate analysis. I introduce each family briefly with some basic demographics and the diagnosis that has been used in the service-user's mental healthcare. All participants were living in one of two London boroughs. Pseudonyms were used for all participants to protect their anonymity. Text in curly brackets are my responses to the participants.

#### **Mary and George**

Mary, 49, and her husband George, 52, had been married for nearly 29 years. They had been participating in OD for 15 months. They both identified their ethnicity as White-British. Mary identified as a mental health service-user who has had a diagnosis of Bipolar Disorder for over 30 years.

#### **The Master Narrative of Mary and George's Experience of OD**

Mary and George explain how OD has given them hope and how it has actually saved Mary's life.

#### **Stages 2-4:**

##### **Open Dialogue as a Life-Saver That Had Taken Too Long to Arrive**

Mary and George describe how desperate they were before OD and what a relief it was to feel supported in OD. They explain how, although challenging, OD has amazingly saved Mary's life. The following extracts from my interview with Mary and George illustrate this change in the quality of their experience, starting with their initial desperation:

George:        ". . . and, as far as we can see, that Mary's in the 'too difficult' box. We really need your help". And he (open dialogue professional) came back with this amazing sentence of, "I can

assure you [Mary] is not in the too diff. . . not too difficult box. .  
.". {Mmm}. . . umm, "We can help you".

Mary goes on to outline her experience of OD:

Mary: It's draining. {Mmm.} It's emotional. {Mmm.} It- It's. . . rewarding.

Through being able to talk about Mary's mental health in OD, Mary and George explain:

George: Boom [clicks fingers]. There it was.

Mary: There was hope.

Researcher: . . . really clear understanding.

George: Yeah. {Right} Yeah, and there was hope, . . .

Researcher: And hope.

George: . . . wasn't there? {Okay. Yeah.} Yeah, there was hope. . . {Mmm.}.  
. . for the first time in. . . Oh my God, years, wasn't there?

The quality of Mary and George's experience of Mary's mental illness in OD seemed to shift from desperation to hope. 'Canonical narratives' are stories that individuals might tell that 'represent broader societal stories of how lives should be lived' (Langdridge, 2007). This narrative is in response to the canonical narratives of the mental health treatment they had been offered prior to OD, described by Mary and George as biological and predisposed. They criticise this prior mental healthcare experience as an infertile context for recovery. Instead this hopeful narrative seems to argue that by being given the space to reflect on herself and her feelings, Mary can feel open to the possibility of her recovery.

Mary however expressed her regret of not being offered OD sooner:

Mary: And I wish I had done it years ago, [researcher], to be honest with you. . .

George sounded frustrated in his addition to this narrative:

George: But it's taken all this time for this simple idea – and it is simple – to get into. . . get over here to. . . to the UK and to. . . maybe the States and, you know. And it is simple, it's. . . All it is is talking.

Mary and George's sadness about the delay of OD was summarised for me by the following extract:

Mary: It was the right time for me.  
George: Yeah.  
Mary: Definitely. {Okay.}  
George: It had just taken too long to get here.

As well, then, as a great sense of hope in this narrative, there was, from my perspective, a certain sense of regret too. Mary's character develops through the narrative from a person in despair, on the brink of giving up on life to someone, who through a radical and challenging process of change, became hopeful again. Through these narratives, Mary and George develop a new sense of who Mary is and who she can be. Rather than being a person with a genetically predisposed mental illness who cannot be helped, Mary becomes a person who can help herself to recover from her mental health difficulties with appropriate support. The idea of Mary no longer being "ill" is developed in this narrative. Rather than there being anything "wrong" with Mary, the main problem is situated within the prior context of suppression.

#### Open Dialogue as Strange at First but Then Empowering

Mary and George describe how strange OD was at first. They then go on to describe how they got used to the approach and how empowering and meaningful this was for them. They portray a sense of trepidation at the beginning of this journey, with fluctuations from sheer excitement to deep sadness along the way. Overall, however, a sense of both relief and conquest seems to resonate from this narrative. In the following extract Mary and George depict the mysteriousness of their initial experience of OD:

Mary: You can. . . You sort of. . . For arguments sake, you say something . . . and there's a pause. Isn't there? And it's getting used to the pause, like, the silence.  
George: Yeah, it's a lotta . . . yeah. A lot of pregnant pauses. {Mmm.}  
Mary: And then you think, well, go on, say something, like, just tell me what to do. {Mmm. Mmm.}

George: But they don't. They don't at all.

Mary and George go on to illustrate how OD has felt like a non-judgemental context in which you feel in control and supported, which has allowed Mary to be exploratory. She describes her self-discovery:

Mary: . . . but I didn't know what the problem was. And it was only when I started to talk and as. . . then the. . . all the onion layers, sort of, start to peel off. . .{Okay.}

Mary: . . . then you think, well, "Do you know what? All these things really have had an effect on my life".

George later explains:

No-one judges you. No-one says, "Ah well that's bec. . . you-you're ill because of this". {Mmm.} You find out those things for yourself. {Mmm.} And then you answer your own questions.

The sense of conquest I perceived in this narrative is rendered in the following quote I believe:

Mary: ...the freedom of open dialogue is that you can say absolutely anything and not be judged, and it's in a controlled environment, if you like. Um, and the joy of it is that I have always been quite frightened of hospitals and doctors; I have been hospitalised, I will admit.

The sense of Mary as a conqueror was further portrayed for me when she said the following:

Mary: ...it sounds really strange, but, for me, I just spoke and I was just honest. And that is what I did. I just knew that I had to talk. And, you know, anybody could have been sitting in the room, to be

quite honest with you. Because I think I just blocked it out who was here.

Although Mary says that anybody could have been in the room, I did not take this literally, but rather as an expression of her new found confidence and volition in that particular context. Mary's confidence in herself and others is strengthened in this narrative. Mary becomes someone who can actually be understood and supported by others, instead of criticised. This narrative seems to argue that, although strange at first, OD provides an opportunity for expression rather than a frightening context resulting in suppression.

#### Family Relationships Deepened by Open Dialogue

Mary and George explain how OD allowed them to say more to each other, which has improved their relationship. The process of how this deepening of their relationship began in OD is depicted in the passage below:

George: They were like a . . . a cushion; they sorta. . . I mean some of it. . . n- not. . . I mean the majority of. . . 99% of what Mary spoke about was nothing to do with me. But, I think, if Mary had told me these things on her own. . . well, she wouldn't have told me these things on her own. I know that.

Mary: I was too frightened. I was. . . I was trying to protect George.

George then clarifies how having the professionals present in OD meetings was useful:

George: . . . I've learnt a lot. [coughs] I think [Mary] has spoken about some things that she consciously had forgotten about, but. . . but a-. . . as a result of. . . talking has churned up lots of stuff that she probably. . . that was probably troubling her that she never realised was troubling her. But I think it helped with [Doctor] and [Care Co-ordinator] being here; they were like a buffer. {Mmhmm} You know? {Yeah} Um, yeah, th- th- th- that sh-. . .

Researcher: It. . . it sounds like you're, George, saying something like it helped you to. . . to listen to that, with them there.

George: Yeah. And also helped Mary to talk about these things. . .

Mary goes on to describe how supportive her daughters have been to her, but also how they and others know her better now:

Mary: ...They've just let me carry on and carry on. And it's. . . I think it's made them understand me as a person. {Mmm.} Um, and that's been good for all of us, because I don't think. . . well, nobody knew what was wrong with me or why I was like I was. But now people understand me.

Mary describes how she and her family have learnt to talk about their feelings with each other more since OD meetings began. Defiantly, Mary explains how she has been able to express herself, without concern about other's judgement or worry about her. She describes how George has, subsequently, been able to help her to cope with her difficult feelings by talking with her. It seems that Mary's confident narrative could be a response to a prior personal narrative of hers of not feeling fully known.

Mary becomes someone who is able to develop deeper and more useful relationships with her family that help her in her recovery. In this way, Mary becomes less reliant on OD meetings and more resilient to the ongoing challenges in her everyday mental life. The idea of Mary's mental health issue as something that is due, in part at least, to her relationship with herself and others becomes further substantiated by this narrative.

#### Friends but on a Professional Level

In a warm-hearted and grateful, but also assertive, manner, Mary and George describe how they felt it was a prerequisite that they had the same professionals throughout OD. They explain how this led on to them developing a relationship with them akin to friendship. George and Mary explain how they became deeply bonded to their OD professionals:



George: ...you are allowing someone in to your. . . to the workings of. . . you know, the innermost workings of your life. {Mmhmm} So you hav- you can't help but build a bond. . .

Mary: Form an attachment. {Mmm.}

George: . . . with these people. {Mmm. Mmm. Mmm.}

Mary: It- it's professional. Don't, you know, don't. . .

George: Absolutely.

Mary: Don't get me wrong, I mean. . .

George: Yeah. I mean, we don't sit here drinking wine and. . .

Mary: Wine or anything {laughs} You know, it's nothing like that.

George: . . . and eating canapés and stuff like that. You know, but. . .

Mary: But they- they are a big part of our lives. {Mmhmm.} They really are. They- they're very important people. {Mmm. Mmm.} Because they've- they've saved. . . me. {Mmm.} Um. . . and I couldn't have done it without them. {Mmm. Mmm} So, yeah, they were amazing. Yeah. I mean, I even went as far as buying [Doctor], um, a present for his new baby. {Mmm.} Um, [Doctor] and [Care-Co-ordinator] Christmas presents. {Mmm.} You know? But. . . we are friends. . . {Mmm.}. . . but on a professional level. {Okay} Aren't we? {George: Mmm.} And I trust him with my life. I can say, now, say absolutely anything to him. {Okay} Yeah. I don't really think there's nothing I couldn't say now. Because I'm not frightened now of him ringing up for an ambulance or anything because I trust him so much, and I think he trusts me; that I am not gonna do anything silly, because he knows now that I would. . . I would ask for help. Whereas, if you'd have asked me this 18 months ago, I wouldn't have even done that. I wouldn't ask anyone for help.

This story is narrated in contrast to Mary and George's experience of didactic professional-patient relationships, which, as they explained, had been their experience of mental healthcare previously. With the trust developed with her OD professionals, Mary seems to argue that she is now much safer. Mary becomes a very grateful mental

health service-user, someone who is able to develop mutual levels of absolute trust with mental health professionals.

### **Laura, Vivienne and Jerry**

Laura, 35 is the daughter of Jerry and Vivienne, both 64. They had been participating in OD meetings for about 4 months. They all identified their ethnicities as White-British. Laura identified as a mental health service-user who had a diagnosis of Bipolar Disorder.

### **The Master Narrative of Laura, Vivienne and Jerry's Experience of OD**

With the supportive and personal context of OD, Laura, her family and others in her social network have been enabled to talk and learn more about Laura's mental health.

### **Stages 2-4:**

#### **Allowing Space for Laura's Voice and Learning More About Her Mental Health**

Laura, Vivienne and Jerry describe how, although they were uncertain about what OD was at first, they discovered that via talking in OD, they could learn more about Laura's mental health. Laura describes how angry her prior mental healthcare made her and, subsequently, how it limited her capacity to talk. In contrast to this Laura calmly describes how OD gave her a voice:

Laura:            Emm, from the experience that I went through, emm this time. From something that's so basic that could have been sorted out so earlier on, I just, I didn't, I just kinda wanted it over and done with, and I didn't really see the logic in it. But after I think about two sessions, I could see how talking emm, in the open dialogue was not just helping me, but it was helping me communicate with mum and dad and the psychologist about exactly how I was feeling when I became ill. {Mmm.} And, they could then understand certain behaviours, that I kinda went through, {Mmm.} Emmm, because of being unwell. {Mmm.} And emm, it just kinda let me have a voice.

In contrast to their prior mental health knowledge and mental healthcare, Vivienne, with a sense of humility, gratitude and discovery, and Jerry with a quality of recognition describe their OD experience:

Vivienne: ...It it has been amazing really. I mean we thought we knew enough about emmm Bipolar but we didn't. And we certainly didn't know anything as much as we know now about her paranoia, which really was awful this time. Although we saw it and we appreciated it, there's no way you can understand it, only the way Laura would describe it.

Jerry: Mmmm. And I think at times Laura, you know probably Laura at times has, has not said a lot because she feels oh it's gonna worry us sort of thing, at the time you know, so if she's you know keeps that to herself. But I think having that platform to start. [...]

Jerry then highlights how feelings were validated by the communal learning environment:

I think it, it makes you feel that there's some value in what those feelings are instead of sort of hiding it away because well that's because I'm ill. You know, the fact that they [the professionals] actually think well yeah you know we understand that. And they're almost learning things that they haven't learnt. The same of all of us. You're learning little bit and pieces that come out about you, and and about the sort of journey through that illness that maybe they haven't come across before.

Following on from this narrative of equality and empowerment, Laura, with relief, describes how she has been able to let her anger go and focus on her recovery in OD:

Laura: ...when you're coming down and all those emotions are phasing in and you, it is really difficult to deal with. So with open dialogue there, you can start releasing all the anger. {Okay} All that rawness emm, that you felt, and kind of still instead of being bitter about

stuff and kind of holding a grudge with some of the nurses you can just kind of get on back with your life. Which is all I ever really wanted to do in June. I never wanted to be ill. And I, you know, something that, I think what open dialogue has done, is just reminded me that I do have a disorder, that I do have to really kind of look after myself.

These narratives illustrate that, to their surprise, Laura and her family have discovered that, through Laura being given an opportunity in OD to describe her experience of mental illness, everyone involved in the meetings has developed a stronger sense of this experience. Rather than Laura being unwell, angry and beholden to the mental healthcare system, Laura becomes understandable in these narratives as someone who is insightful about her mental health and can care for herself more independently.

#### A Free-Flowing and Supportive Conversation, in Which Multiple Viewpoints are Encouraged

Rather than feeling subjected to the agenda of professionals, Laura and her family describe the free-flowing and supportive nature of conversation in OD. They describe how this allowed for important topics to be usefully explored together, with multiple viewpoints encouraged. The relationships developed with professionals in OD were described as very personal. With a sense of freedom, Jerry, Vivienne and Laura describe the nature of this free-flowing conversation:

- Jerry: The fact that there is no sort of holds barred, you just sort of come up with sort of things and it just makes a more relaxed atmosphere.
- Vivienne: Oh yeah
- Jerry: So then you naturally flow into other things where you know
- Vivienne: Yeah, like what have you done this week or where you gonna go or who you gonna see? Things like that.
- Laura: It obviously changes for their, the way, more how better I am. {Okay.} So the conversations that now that I'm having now, it wouldn't necessarily happened at the start...

Towards the end of the interview Jerry adds:

...at times it feels like we're going over old ground but you know like even like now we're going back over things because you can't actually separate that from what's happening now because it's all interlinked...

With gratitude, Jerry and Vivienne explain how this conversation style has allowed for Laura's needs to be appreciated and responded to more:

Jerry: Because when you're just talking naturally you can't hide how you're feeling you know.

Vivienne: Yeah because she was very good at that, at at hiding how she felt to the outside world probably.

Jerry: And I think that's another aspect of the therapy that it's operating on different levels. It's that monitoring thing as well because they can go well actually she wasn't, she was a lot brighter last week, you know.

Vivienne: Yeah I wonder why.

Jerry: And without actually going into it they can say well you know why do you think you can't get up in the morning, well emmm, and

Vivienne: Which came up this time, yeah right. And that followed on to the fact that emm, about this plan. How she felt let down and not really going to work wasn't it. That's how that all came out.

Jerry appreciatively describes how the multiple viewpoints in OD led to a broader understanding of Laura's mental health:

Jerry: ...It's totally, you know, it's just one thing goes to another and then if someone else, like when John, emm, our other, emm Laura and James, emm Emma and Jack, our other two children were in on it [Jerry appears to get names muddled here but it seems he is referring to Laura's 2 siblings], it went a different way you know,

because they had their input and things that they've noticed with Laura's behaviour or, or things that they'd felt whilst Laura was in hospital, emm took us off in a completely different direction and, and it opens up our eyes to certain aspects...

With an exploratory quality, Laura explains how taking a wider perspective is encouraged by the professionals' reflections:

Laura: ...they're are being really really honest. And it gives you food for thought as well so they're talking about things. So you know they're really really listening to you. [...] because you may not have thought about how they've discussed the situation before. So you kinda go oh I didn't realise.

Moving from a feeling of embattlement to a sense of intimate comfort, in the following narrative Laura, Jerry and Vivienne contrast their prior relationship dynamic with mental health professionals with the dynamic they experienced in OD:

Jerry: Like you against them sort of thing.  
Vivienne: Like you against them sort of thing. It was almost like,  
Laura: A happy  
Vivienne: It felt like cosy.  
Laura: Yeah cosy

In contrast to Laura's experience of animosity with inpatient mental health professionals, Jerry and Vivienne warmly describe their family's relationships with OD professionals:

Vivienne: Yeah, it's really good. You're calling everybody by their first names. {Okay} We all kiss hello and kiss goodbye. {Okay} It's like a big friend meeting now. It's personal and  
Jerry: Yeah that's what I mean it's very personal situation.

It seems that before OD the opportunity for Laura and her family to explore their experience of Laura's mental healthcare had been limited. This group of narratives illuminates the opportunity Laura and her family have had in OD to explore this story. Through doing so, Laura's identity in relation to her mental health becomes intimately understandable from multiple viewpoints, which, it seems, leads to her feeling very comfortable and trusting of others in OD.

#### Spreading the Openness; "it's like a ripple effect" (Jerry)

From experiencing, or being told about, OD, Laura and her family describe how they and others in their social network have found that they talk a lot more now about Laura's mental health. Laura and her parents describe how helpful this has been. Laura, Vivienne and Jerry excitedly describe this perpetuation of openness:

Jerry: I think even the fact that they're not there when Laura meets them, you know open dialogue comes up because we talk to lots of people about oh yeah we had a session and this is what happened, and, and although your sort of transmitting third hand if you like, you're still getting those points out with no sort of emm, barriers or anything, and you know Laura will talk to her friend and... it gives you a more openness.

Laura: Yeah, and it works in another wave.

Jerry: So although you're not, they're not in on the session, it's easier for you to transmit what went on in the session and they can you know, so, so its al-most like relayed. So you know it.

Vivienne: Yeah we've told so many people about people about it now haven't we?

With gratitude and relief, the following extract describes how this ongoing openness and OD meetings themselves have been helpful for Laura's parents:

Laura: ...[T]hats their sort of therapy with their friends as such.

Vivienne: Well I think this has helped us as well Laura. To be honest.

Laura: Yeah

Vivienne: Don't you think?  
Jerry: Yeah totally.  
Vivienne: Yeah I mean it's really been enlightening I think is the word.

Again with gratitude, Laura and Vivienne convey Laura's experience of this openness within her wider social network:

Laura: All the friends, you know the close friends I've had I talk about open dialogue, they all seem like pretty interested in the same way when dad talks about it or mum talks about it to their friends. They're very like, oh how's everything gone? And I say ah, I had open dialogue. And they go what did you talk about? And I talk about it with them.  
Vivienne: They've been brilliant. They really have.  
Laura: Really really good. And we talk about, we just talk...

Rather than something that can only be dealt with by Laura or with professionals, Laura's mental health in these narratives becomes something that is not only readily accepted as a topic for discussion by her social network, but as something that can be discussed in this context in a supportive manner. There is a suggestion that, in contrast to prior mental health treatment, Laura and her parents have found OD facilitative in enabling this ongoing dialogue. To friends in Laura's social network, Laura's developed sense of who she is in relation to her mental health is shared. Furthermore, in these ongoing social network dialogues, there seems to be potential for Laura's identity to continue forming.

### **Dave and Sharon**

Dave, 47, had diagnoses of Generalised Anxiety Disorder and Depression; he said that he has had anxiety for most of his life. Sharon, 68 is Dave's mother. They both identified as White-British. They had been participating in OD meetings for over a year.



## **The Master Narrative of Dave and Sharon's Experience of OD**

Although uncomfortable for Dave at the beginning, with time he reported feeling more at ease with OD. Sharon and Dave portray the complex family dynamics they live with and they explain how particularly important it is for Dave to feel heard and believed, which they explain was the case in OD.

### **Stages 2-4:**

#### Going Into OD Blind and Scared, but Over Time Becoming More Comfortable

Dave explained that he had no idea what OD was, but that he is someone who wants to recover and, therefore, was willing to try it. Despite not being sure if he could trust the OD professionals, feeling embarrassed about how he was feeling and strongly wishing he could avoid OD meetings, Dave explains how persevering with the meetings led to him becoming more comfortable with them. In both a fearful and determined way, Dave explains how he was able to engage with OD:

Dave:           “Well, yeah, I’ll give it a crack” – I didn’t have a clue what it was. You know what I mean? {Mmhmm.} An- And, I’ll be honest with you, the bit that made me really apprehensive was that it was done at home!

Dave later elaborates on this feeling:

And- and. . . Just, I can- all I can remember was thinking, “D’you know what? I- I- I just wanna give it a try”. You know what I mean? “I just wanna give it a try, see what happens”, and, uh, and all I could re-, uh, th- th- the early pa- early part of it, all I could remember was these three people coming along – obviously one of them I knew, which was. . . which was [doctor] – and then there was these two other ladies that come along, one of them’s [family therapist], now I know, and, em. . . So I then, obviously, like I said, was quite apprehensive. I’m very much don’t wanna talk to anybody, try and build walls up, because j- . . . I’m paranoid that if I tell anybody and they think. . . they could almost use it against me. Do you know what I mean? {Mmm} And- And, uh, that’s

always how I felt. Do you know what I mean? I don't wanna tell anybody anything because they could in some way harm me.

Dave later clarifies:

...I think if, in the beginning, I think if that open dialogue hadn't have been at my house. . .{Mmm.} It would have stopped. . . . I wouldn't have done it. I wouldn't even have carried on. {Mmm. Mmm.} I think I can honestly say that to you.

This narrative is in response to Dave's description of prior experiences of not being able to trust others. Dave also explains that it is hard to express his feelings to others because of his identity as a man. These apprehensive narratives, therefore, can also be perceived as an implicit response to the canonical narrative of men being expected to show strength rather than vulnerability. I wondered whether my identity as a man, and, therefore, as someone able to relate to canonical narratives of masculinity, may have helped Dave feel able to express his vulnerability as a man. Despite being very guarded and not knowing what OD was, Dave was willing to try it. Despite this determination, this narrative seems to argue that it was necessary for OD to be at Dave's home for sufficient trust to develop. In the final extract of this set of narratives, Dave becomes more trusting of the support of OD:

Dave: I can honestly say that I find- I find th- th- the sessions re- really helpful. Do you know what I mean? {Mmm.} I- I didn't think I would. {Mmm.} And I, eh, in the beginning I didn't wanna say anything. I didn't wanna say too much. Do you know what I mean? But, I've started now. . . it's taken probably two years – I've needed, two years – to get comfortable with the situation, but. . . {Okay}. . . now, it's nice.

Although there is a certain sense of relief in the way Dave makes this statement, the narrative implies a long period of Dave feeling uncomfortable in OD too. This time frame of Dave's discomfort suggests that Dave has really persevered with OD. The idea of him as a fighter, again, comes to my mind.

## Getting to Know Dave Beyond his Diagnosis; Considering Family Perspectives and Dynamics

Dave, in a warm and grateful way, explains how he can talk about anything with OD professionals now, which he describes is, now, a relaxing experience. Dave explains, appreciatively, that these more diverse conversations allow professionals to get to know him more fully. Again with gratitude, Dave explains how these professionals have also been able to get to know him better by having witnessed his distress, as it, sometimes, manifests at home. In the following extract, Dave seems to explain how he felt disregarded by his prior healthcare, in contrast to his experience in OD:

Dave:           ...So, it's not all about, just giving me a . . . a prescription and- and waving me off. Do you know what I mean? They [the OD professionals] then become a bit more knowledgeable of, like, how, I don't know, how Dave ticks maybe...

Dave and Sharon seem to argue in the following extract how professionals can learn more about Dave's mental health by witnessing his behaviour when distressed at his home, as well, then, as by listening to Sharon's reflections on it:

Sharon:        So it was a bad-good thing, almost.  
Researcher:   In what way was that helpful?  
Dave:          Uh, that helped. . . I th- I think it wasn't so much helping me. . .  
Sharon:        No.  
Dave:          . . . at the time, but it. . .  
Sharon:        Helped [OD professional].  
Dave:          . . . it gave them an insight – or gave her an insight. {Yeah.}. . . into  
                  me  
                  in a day-to-day. . . I suppose that they could see reality. Whereas,  
                  like,  
                  I suppose. . . as professionals, they- they don't always necessarily  
                  see  
                  the good and the bad, they just see you as a . . . a patient and you

discuss things. But you can't always see things first-hand.

With resolution and confidence, Sharon goes on to describe how sharing her experience of caring for Dave in OD has helped her to accept that she cares for Dave appropriately:

Sharon: I mean, from my side it's sort of like, what I've tried to do in supporting Dave, I've done it the right way.

She also, humbly, describes, however, how she has learnt from OD how she can manage her anxiety:

Sharon: And I think that's where it's helped me. It's sort of like, you can't. . . your mind cannot control everything at once and you've got to start. . . think to yourself, "No, that's not important. Stop worrying about it".

When Dave gets angry, Sharon explains how she has learnt in OD that she can show him more effectively that she cares:

Sharon: I'm, sort of, more. . . I'm trying to- try and diffuse the situation. Whereas, before, I probably triggered it to make it worse.

Sharon's narrative of becoming more confident about her care and learning from sharing her experiences in OD seems to argue that, even if a carer has a very good relationship with a service-user, as Sharon does, that they can still find valuable support from sharing their experiences in OD.

By having flexibility about which of them attends OD meetings, Dave and Sharon explain, thankfully and with some relief, how they are better able to discuss complex family dynamics in the meetings. Talking together as a family in OD is, thus, suggested in the following narrative as not necessarily being the most useful way of facilitating communication in OD:

Sharon: ...I had to, get up and say, "Is it OK if I leave?" And, eh, I left you for quite a while [...] {Dave: Mmm.} And then there was another session where, em, Dave actually said, "Do you mind if I sit on my own?" because he wanted to discuss things that he knew would probably hurt me.

In this set of narratives, Dave's identity, beyond his anxiety and diagnoses, develops. Rather than being the only person with difficulties, Dave becomes known as a member of a family which has difficulties that are hard to discuss. Dave can be seen as both wanting to protect his mother from being hurt and, also, wanting her to understand how he feels. Given that this complex family dynamic seems to exist, I wondered what else Dave or Sharon might have said to me about their OD experience if I had interviewed them individually.

#### Open Dialogue as Genuinely Caring, Respectful and Supportive

Dave explains how he felt respected, believed and supported in OD. In the following extract, there is a sense of Dave's frustration and fear in regard to his prior care, which is distinguished from his gratitude for the respectful support he describes having experienced in OD:

Dave: ...I've been able to. . . to realise that there won't be any judgement. You know? They genuinely. . . I do- I do. . . I do believe that they're there and they're trying to help me. Do you know what I mean? Where. . . I don't know. . . In the past, maybe, I just didn't think anybody really cared...

Resonating calm resolve, Dave explains the most important part of his OD experience:

Dave: The biggest thing. . . The biggest thing is probably just being believed.

Sharon: Yeah.

Researcher: I hear that from you.

Sharon: Mmm. {Um...}

Dave: It's just being believed.

Researcher: I hear that.

Dave: It's just being. . .{yeah} It's just being- being accepted. That. . . You know? "You are unwell but we can see that you're trying to help yourself." That. . . I don't want people. . . That's my worst fear, is that people'd look at me and they'd think, "Do you know what? He doesn't help his self".

With pride, Dave describes how he has used other supports to become more motivated and hopeful. Appreciatively, he summarises how he has experienced OD as contributing to this support:

Dave: And that's not always because of the open dialogue group. That's because of other. . . That's because of all of the different things that I've tried. But, to have that support, to . . . Basically, I suppose what I'm saying is it's nice to have that as a- as a safety net.

With compassion, Sharon appreciates how OD professionals have helped her and Dave just by kindly listening:

Sharon: ...I think the open dialogue is- is having a special nan, shall we say. To anybody- anybody, but to. . . particularly to mental health patients, somebody that will sit and listen and not judge.

The narratives within this theme were told in contrast to the supportive, but fragmented and hard-to-reach professional help Dave describes trying to access before. These narratives assert the importance of reliable warm support for both Dave and Sharon, but, particularly, Dave. Dave becomes someone who can find emotional stability from being wholeheartedly acknowledged and respected by others.

## **Sheila and James**

Sheila was a 28 year old White-British lady who had a diagnosis of Schizophrenia. She had been participating in OD for around 6 months. Her husband James was a 27 year old White-British man who had attended some of the early OD meetings with Sheila.

### **The Master Narrative of Sheila and James's Experience of OD**

With ongoing perseverance, Sheila has continued to learn about the origins of her mental health difficulties and how they are maintained. By sharing her experience of these difficulties with professionals and James, she has learnt that she can trust others with this information and feel more compassionate towards herself and others.

### **Stages 2-4:**

#### **Sheila Felt Able to Explore her own Mind in Open Dialogue**

Despite feeling guilty, embarrassed and ashamed when she started OD, Sheila, appreciatively, explains how she was encouraged to explore her associated thoughts and feelings in OD. Sheila, gently but assertively, describes how, since exploring her mind in this way, she has been able to feel less self-critical and more in control.

Sheila: I think it sort of made me realise that actually, uh, I'm that one that has control over, you know, my mind and my thoughts, em, as much as anything else, you know. Like, wha- . . . other people's ideas, or intrusive thoughts. Em. . . Em, and [OD professional] and [OD professional] have always- have- have been really understanding, and I've never felt judged by them. Anything that I've ever said, even things that are, like, really, em, you know, that I haven't really have told anyone or been too, like, ashamed- I've felt too ashamed to discuss with anyone, it wasn't a problem.[...] Thinking about it rationally and s- saying that you realise that some of those things that happened weren't because of you, or it wasn't your, em. . . it wasn't your fault or it wasn't. . . you didn't instigate it or anything like that. Um, that's helped quite a lot of the problems that I was having.[...] With the open dialogue I found it easier because of. . . If there was something, you know,

important, you know. . . something, you know, that there wasn't a time limit or anything like that. {Mmm.} Like, you know, if you was getting somewhere, you could continue. It wasn't like. . . {Mmm} . . . you know, em, "Oh you. . . 7 O'clock now. You gotta go". And then you think, "Yeah, it's not that interesting. People ain't interested in it".

Sheila's narrative suggests that having understanding professionals and time were important factors in her experience of empowerment in OD. With clarity, sadness and relief, the following narrative of Sheila's experience asserts the value of exploring the origins of her distress. Sheila shows herself as someone who has struggled with the complexities of her mind and the impact of her past, but, as in the narrative above, is also an investigator after the truth:

Sheila: I think it, like, made me realise a lot of the time that I don't, em, trust other people, or, em, other- other people don't, em. . . are not real. Their, um. . . their like, compassion towards other people isn't real. Em. . . Because of. . . I'd, sort of, experienced that a bit at home with my mum and dad [...] I think a lot of people would probably blame their self, or. . . blame other people. Um, and I think those feelings and thoughts were getting tangled with other ideas and it was all, sort of. . . it was all, sort of, going round in a circle. And I'm trying to just, sort of, pick that apart now and. . . {Mmm.} . . . learning that, just. . . just because I feel something doesn't mean. . . If I feel anxiety and I feel fear and I feel. . . that doesn't actually mean that I'm in any imminent danger.

With a sense of relief and enjoyment, Sheila told me how, since OD, she has been more able to think about who she is. The following narrative portrays OD as having freed Sheila from the confines of her own anxiety. It seems that, after a long time of feeling encumbered by her anxiety, Sheila has been allowed some space now to explore who she is:



Sheila: It's made me realise a little bit more about myself and it's given me free, sort of, mind. . . free- freedom in. . . in my mind to, sort of, explore a little bit more about myself. Like, what things I like and what I don't like. Whereas, before, I never used to think about things like that. [...] So, I feel like I've got that- a little bit more, um, personal time in my mind where I'm not constantly thinking about, "This is happening, this is happening. Hey you do this, hey you do that. How you gonna get out of this. What you gonna do?"

Through the supportive space afforded to her in OD, Sheila's character in these narratives has an emerging presence, which appears to be in development; who she is and who she might be seems to be being explored tentatively. She becomes present as an observer of her own mind and, subsequently, as the person who chooses how to respond to what she sees.

#### Open Dialogue is Hard Work but Recovery Became Tangible

Sheila and James describe how OD was awkward and upsetting at first for Sheila. As well as her uncertainty about what to do in OD, Sheila, then, goes on to explain how her feelings of guilt, shame and embarrassment made it very hard for her to share her difficulties in the meetings. The discomfort of Sheila and James' initial OD experience resonates in the following extract:

Sheila: Em, just a bit awkward I think. {Mmm} You know, you don't know what to say or. . . {Mmm} . . . and it- it was quiet for long periods of time. You think, "What should I say? What do they wanna hear?" I just want them to feel like everything is alright and, you know, over and done with. {Mmm} Em. . . It was quite a while ago now, innit, since you've been, so I don't know what you, kind of, remember or. . .

James: Um. . . I don't remember a lot about it, but I remember you- you were very upset at the time, like. . . {Sheila: Mmm.}. . . when you were trying to get things out.

Sheila explains that she didn't want to invite her mother to OD meetings in order to avoid hurting her or feeling criticised by her. She admits that she might not have been so honest in OD if James had attended more meetings, due to her feelings of shame and embarrassment. Although the following narrative contains unresolved sadness, I also heard Sheila's gratitude for the privacy she has been afforded in OD:

Sheila: It's quite a tough one. I think with, like the embarrassment and the guilt and the, sort of, like, you know, ashamed, I felt guilty and embarrassed of being ashamed. {Mmhmm.} Do you know what I mean? {Mmhmm. Mmhmm} I know that. . . it's such a vicious circle, really, I think. I think the whole- the situation is just such a vicious circle, I feel, like, that open dialogue has, sort of, broke that cycle a bit for me. {Mmm.} It still- it still takes a lot of effort and a lot of, you know. . .

Counter to the encouragement Sheila says she had from professionals to invite her mother into OD, Sheila and James' narratives thus far maintain the importance of privacy in OD given the vulnerability evoked in Sheila in OD. Sheila's protectiveness of herself and others transpires from these narratives.

As well as persevering, despite the difficulties illustrated above, with relief and hope, in the following narrative Sheila encapsulates how she has begun, via OD, to get a sense of what recovery from her mental health difficulties can be like, and, subsequently, what she can continue to aim towards:

Sheila: [...] I always desperately had wanted to get better. Em, but I never really knew what better was. I never really knew what well was. People said, "Oh, we're going to get you to recover", and I'd be, "Well, how do I, then, when I'm better?" Or. . . {Mmm.} "How do I know when I have recovered?" But, now I'm starting- now I'm starting to see recovery. [...] It's just, um, not taking those thoughts and feelings to the extreme and then not interfering

and bothering you in your daily life. It's not about, you know, oh.  
. . you're going to be euphoric and bouncing around, you know.  
<laughs> {Mmhmm. Mmm.} It's more. . . {Mmm.} . . . em. . . Which  
is good. I feel like I've got more of a realistic target to work  
towards.

The above narrative seems to be a response to canonical narratives of "recovery" in NHS mental healthcare. It criticises these narratives as hard to understand and intangible. Instead it claims that OD provides the opportunity for individuals to discover what recovery means, particularly to them. Sheila also suggests that OD came at the right time for her as she was motivated and self-aware. In these narratives, Sheila is the protagonist in her recovery, with the timely support of OD.

#### Becoming More Accepting of Oneself and Adjusting Attitudes to Others

Sheila describes how she learnt to trust OD professionals. Subsequently, she explains how, in OD, she understood her mental health difficulties and the origins of these. By considering why her mother may have treated her in the way she did, Sheila said that she was able to let go of some of her feelings about the past. With sadness and relief, Sheila describes her uncovering of the origin of her troubles:

Sheila: I realised that I was probably . . . had been quite a victim of  
circumstance. You know. I had a difficult time at home when I was  
younger, and had to, sort of, just, um, brush it all away, all under  
the carpet. You know. Don't talk about it and- . . . I still don't now.

A little later, she reflects on how discussing her past has affected her:

Yeah. I think it's helped me, um, let go of a lot of things. {Mmm.}  
Um, a lot of feelings of, you know, like, anger, resentment, um. . .  
fear.

Further on, she adds:

I think it, like, made me realise a lot of the time that I don't, em,  
trust other people, or, em, other- other people don't, em. . . are

not real. Their, um. . . their like, compassion towards other people isn't real. Em. . . Because of. . . I'd, sort of, experienced that a bit at home with my mum and dad [...]

Referring to this developed self-understanding and her mother's upbringing, Sheila later explains however:

It makes you realise it's not, you know, em. . . she wasn't just doing it to you just because of <laughs> it's you, you know. {Mmm.} You know. Like, it's not- it's not a personal thing, it's just the way that things are.

Sheila explains how she accepted her mental health difficulties more in OD:

Sheila: [...] I think, um, you've gotta start learning. And- and it takes a long time and it takes a lot of, um, effort to think, you know, that this is your. . . em, problem (I don't like saying problem). {Mmhmm.} That this is. . . This is the way it is. You know. {Mmm.} And accepting it and knowing, that, um, the ideas are just the way your mind is, I suppose. Em, you're more likely to think of these ideas and these, you know.

These narratives persuade me that OD enabled Sheila to accept her mental health difficulties and their origins. Instead of being told what her difficulties were, it seems that Sheila was actively involved in learning for herself. Sheila gains ownership over how her past impacts on her in these narratives.

By accepting what her difficulties are, and how they originated, Sheila illustrates, with a sense of being released, how she has reconsidered her expectations of others since OD:

Sheila: [...] there are things that I don't like about, um, myself, um, and what I, um. . . but I have just, sort of, accepted that, you know. Like, I've, sort of- I've always expected, like, perfection from myself, and a hundred per cent effort from other people and. . .

{Mmm.} . . . that's not realistic. Do you know what I mean? You can't, like. . . <laughs> {Mmm.} Things don't work out that way. [...] I've realised that nobody actually, um, is a hundred per cent perfect. Whereas my parents have always wanted me to be a hundred per cent perfect and expected a hundred per cent. Doesn't mean I have to expect it and I have to, um, live by that same standard.

Sheila highlights, in an appreciative yet, also, pensive way, how, since discussing her concerns in OD, she has been able to share more of her difficulties with others:

Sheila: [...] It has got a lot easier. Um, and it's made me challenge the way that. . . maybe, you know, other people don't want to sabotage me, maybe, uh, maybe, you know, em. . . I think I have been more open, honest, to other people closer to me than what I originally was.

Sheila and James, later, discuss an example of this:

Sheila: I feel like I- I can say "I, em, I can't make this phone call because I think this is gonna happen", whereas, before I would be like, "Don't tell him what you think's happening because of. . . he'll- he'll know and he'll tell them people and they'll, em, confer and find another way and. . .". Do- Do. . .

James: Oh, I understand what you're saying. I know what you mean now. {Mmm.} Yeah, it's definitely got better in the last 6 months. Definitely.

These narratives of Sheila's relationships beyond OD seem to make the case that Sheila has been given more choice about how she relates to others through OD. Sheila almost seems freed from her past with this availability of choice, but it appears that her past continues to play a large part in her experience. To some extent, she now seems to be

able to understand how much her past influences her current relationships with others. Although James has not attended OD meetings with Sheila since they began, and Sheila did not know me, she chose to share her very personal experiences with us and did so without much evident distress. This seems to be to me a demonstration of Sheila's strengthened confidence in expressing herself to both professionals and James.

### **Alfred and Jennifer**

Alfred was a 21 year old man. His mother Jennifer was 50. Jennifer said that they were both White-British. She said that Alfred had been given the following diagnoses: Asperger's Syndrome, Depression, and Social Phobia.

### **The Master Narrative of Alfred and Jennifer's Experience of OD**

Although challenging, with time and caring professionals, Alfred and Jennifer have been able to trust and open up to these professionals. Empathic professionals enabled Alfred to understand and accept some of his mental health difficulties more. Other family members also learnt more about Alfred's mental health via OD, which led to Jennifer feeling more supported.

### **Stages 2-4:**

#### **Getting to Know and Trust Each Other; Allowing Alfred to Gradually Find his Voice**

Although uncomfortable at times during OD meetings, Alfred explains how these meetings have made him feel better and Jennifer highlights how they are positive, despite the challenges involved. Alfred and Jennifer describe how they have been able to feel more comfortable and how Alfred has felt more understood and accepted in OD. Jennifer recognises how OD allows Alfred to listen to others and speak when he feels comfortable enough.

Reflecting both the discomfort and comfort in their experience of OD, the following narrative illustrates how, for Alfred and Jennifer, meetings were hard, but, also, supportive and rewarding. Despite finding such social situations challenging, Alfred begins to be known here as appreciative of the relationships he has developed with professionals:

Alfred: Um, it's been sometimes helpful. . . {Mmm.}. . . em, and sometimes difficult. {Mmm.} Em, s. . . sometimes, but, I feel like afterwards I feel better. {Mmm.} But, in the meeting, sometimes I feel like, em, too much – all eyes on me.

A little later on Jennifer adds:

I think there are times when we feel – whe- where everybody, not just us – everybody feels, “What should we say next?” You know. {Mmm.} “Where should we go now?” – with the talk. And so, em-em, [Alfred], you know, finds social things difficult anyway. [...] Having said that, um, it's also- it- it. . . although we don't always know what to say, it's a- it's a nice feeling – the hub (the OD meeting). It's, uh, it's very calming. Everybody's. . . Everybody's very caring. You know. [...] It feels like they. . . it's a. . . it's a positive thing – even when you don't know what to say. {Mmm.} The whole- The whole, eh. . . em, the environment is positive.

I became aware at this early stage of the interview that Alfred may feel uncomfortable if he felt that too much attention was on him in the interview. I wanted to include his views as much as possible in the co-construction of his and Jennifer's narrative of their experience, but I realised I would have to be sensitive to his discomfort in group discussions.

Jennifer describes how the experimental nature of OD had led to her, Alfred and the professionals discovering that meetings are much more relaxing at home. With a sense of tension easing, the following extracts illustrate how Alfred and Jennifer have valued getting to know their OD professionals. Time and compassionate care seem to be identified by these narratives as necessary factors for developing trust with professionals:

Jennifer: You know. It gets easier as you go along 'cause you feel like they get to know you. {Mmm. OK.} I would say so. Make. . . Become. .

. {Mmm.} . . . more relaxed as time goes on and then the more relaxed you are the easier it is to speak, isn't it?

Researcher: Yeah. Yeah, totally. Would you agree with that [Alfred]?

Alfred: Yeah.

Later in the interview, Jennifer adds:

Jennifer: If I didn't feel as though they were wanting to help and they were caring. . . {Mmm.} . . . then you- you wouldn't be opening up. {Mmm.} And you wouldn't be feeling like you can trust them, and that kind of thing. {Okay} So, em, the fact that Alfred is talking more. You know. The fact that I felt comfortable with them. {Mmm.} Em, it's because of how they are.

Consistent with the above story of developing relationships, Jennifer pronounces how "vital" it has been that they've had the same professionals throughout their experience of OD. Beyond these relationships, Jennifer outlines, with appreciation, particularly how the meetings have supported Alfred's mental health:

Jennifer: [...] it's not geared towards the Autism. . . {Mmm.} . . . at all. {Mmm.} Um, but I think it's. . . it's helped with the. . . with the down side. You know. With the feeling down. . . {Mmm.} . . . that runs alongside the Autism. {Mmm.} Em, with the – you know – acceptance and the validation and the – you know – this is. . . and the understanding. . . {Mmm.} . . . and that kind of thing.

I, then, go on to ask Alfred how his understanding about his low mood has developed in OD. His response is also appreciative:

Alfred: . . . I don't know, when they sometimes reflect, or something, then they talk about, like, um, like, a lot of the time I, like, struggle to just even, like, get out of bed. {Mmm.} And they talk about, like,



how, if you're feeling low, then no-one would feel like they want to get out of bed.

This narrative portrays the crucial role in Alfred's experience of OD professionals recognising, understanding and normalising the way he feels. It seems that Alfred also appreciates being able to recognise and accept these difficulties more himself. From others' reflections, Alfred recognises himself. It seems, subsequently, that he can now further articulate his challenging experiences himself. From the narratives presented thus far, Alfred has become someone who others can relate to and understand. Like lots of people, he seems to require time to get to know and trust others before opening up to them. As well as having time to generate such relationships, having the space in OD to choose when to listen and when to speak is appreciated by Alfred and Jennifer. With some contribution from Alfred, Jennifer respectfully conveys this experience:

Jennifer: Sometimes I kind of find I speak for Alfred a bit. Um, and I try and encourage him to speak for himself, which he is doing really well today. Yeah.

Researcher: Oh, Ok. So, Alfred, how do you find having your mum in the meetings, in that way? Does she help you say what you want to say?

Alfred: Yeah.

Jennifer, later, adds:

The thing is, when. . . Sometimes in the meetings when Alfred doesn't say very much, em, he's. . . he likes listening to everybody else. . . {Mmm.} . . . he's- he's not upset. You know. It's not that, um. . . It doesn't bother him that he's not contributing. But he wants- he wants to hear everyone else talking.

Jennifer, later, concludes:

[...] it's a good environment for- for- for, em, like, encouraging Alfred to speak. Definitely. [...] The main thing is that it's a caring environment. {Mhmm. Okay.} I think it's – you know – it feels therapeutic. It doesn't feel, um, rigid or – you know – you don't feel as though – I don't know. . . It just- it just feels as though it's about Alfred getting better and. . . {Mmm.} . . . and people care about that.

This final narrative, was in response to what Jennifer describes as “clinical” ward round meetings; meetings that were so uncomfortable for Alfred that he had to leave on several occasions. The above narrative encourages me to perceive the flexible nature of OD meetings as a factor that enables Alfred to express himself more. Both within this narrative and the other narratives explored above, Alfred's discomfort with opening up to others becomes clearer; his motivation for self-exploration within the accommodating context of OD, however, also becomes more apparent.

Although Alfred agrees that Jennifer helps him to speak in OD, I wondered about the extent to which Jennifer speaks for Alfred in OD, and the extent to which Alfred allows this. Jennifer said that she tends to find herself talking for Alfred, but it was not clear in which context or contexts she was referring to. In any case, it seemed that Jennifer's presence in this interview significantly aided the construction of Alfred's narrative of his OD experience, rather than hindering it.

#### Feeling More Supported by Family Members Having Invited Them to Open Dialogue

Alfred and Jennifer said that some of their family members have gained understanding about Alfred's mental health by attending OD meetings. They explain how being able to choose to invite one additional person at a time to meetings has meant that including others has been a positive experience for Alfred, rather than an overwhelming one. In the following extracts, it appears that Alfred has gotten closer to his mother's partner and his grandfather since OD, but that it is uncertain to what degree OD has played a part in this. Jennifer's optimism about how OD may be able to contribute to the development of positive relationships in her and Alfred's family, can be identified from her contribution to the narrative.

In response to me asking Alfred if his relationship with his mother's partner has changed since OD he responds:

Maybe. I don't know if it's, like, to do with that though. {Mmm}  
'Cause we went away for a weekend. {Yeah.} And it might have something to do with that.

Researcher: Oh, OK. That's something a bit different from what you've done in the past?

Alfred: Uh, I feel like he wants to, like, help and stuff.

Jennifer adds to this a little later on:

He- Alfred is definitely closer to [Jennifer's partner] now, and I think you are to Grandad as well, aren't you? But, as you were saying, it is difficult to know whether- what has caused what. {Mmm.} Em, so, you can only s-, o- o- on reflection, you can only say it's definitely not been a negative if we've all got- if they- Alfred's got closer to them. {Mhmm.} It definitely hasn't had a bad effect. {Mmm.} Yeah. Whether it's had a contribution or not, I'm not sure. {Yeah.} But it probably has. {Okay} Probably has. But we- we can't be definite on that. {No. No.} Um, yeah, Alfred's, uh, spending a lot more time with both of them than he was.

Jennifer, gratefully, explains how she feels family members have become more understanding of Alfred's mental health since OD and how this comforts her.

Jennifer: Because sometimes when you're, you know, I'm. . . it's been, sort of, me and Alfred, and me knowing the problems more than other. . . other people. {Mmm.} Um, and, so, for them to be, to participate in something like this, um, that helps m-. . . that helps me. {Mmm.} To know that they have more understanding.

Researcher: Mmm. Mmm. I suppose you are less alone in what. . .

Jennifer: Yeah.

Researcher: . . . in all of this.

Jennifer: Yeah.

Jennifer emphasises that she does not criticise her family members for not having understood as much as they do now, for they have not experienced what it is like to care for Alfred as much as she has. She conveys how OD has been a way of offering these family members a way of getting closer to this experience and supporting Alfred. Although it is unclear quite how, beyond Jennifer's appreciation of others being more understanding, these narratives seem to suggest that involving family members in OD can help nurture more supportive family relationships, for both Alfred and Jennifer. They seem to argue that *being with* Alfred's mental health difficulties, rather than *talking about them* facilitates understanding, and that, to some degree, OD offers the former as well as the latter. Within this narrative theme, Alfred can be identified as part of a family, some members of which have been uncertain of how they can reach out to offer their support to Alfred. Alfred seems to become more reachable, as family members are described as now being closer to him.

### **Stage 5: Destabilising the Narrative**

**The Empowerment of Service-Users and Families via Open Dialogue:** Every family situated their OD experience within the context of their prior NHS mental healthcare; it seemed that they had all been significantly relying on NHS mental healthcare prior to commencing OD. The mental healthcare they had been given, however, seemed not to have been tailored to their individual needs, at least not to the extent that they described in their subsequent experience in OD. Families told stories in which their opportunities for expressing their difficulties, for developing understanding about the difficulties and for developing ways of coping had been limited before OD. From the perspective that empowering organisations are those that enable people to regain control over their lives (Zimmerman, 2000), the NHS mental healthcare families received

before OD can be seen as disempowering. For example, Mary's mental healthcare prior to OD can be understood as having contributed to the following aspects of her mental health: feeling hopeless, helpless, alone, powerless and reliant on professional support. Zimmerman (2000) suggests that critical understanding of one's environment is crucial for individual empowerment. In these narratives of traditional NHS mental healthcare, service-users' critical viewpoints about these understandings may have been prohibited by the expectation that healthcare professionals were the experts on their experience. This may have negatively affected the other components of Zimmerman's (2000) empowerment theory: one's belief in being able to exert control and one's ability to make decisions. Given the vulnerabilities of these service-users, their mental healthcare prior to OD could be described as uncompassionate, controlling and socially rejecting, like Foucault's (1988) criticism of the disregard of the subjective experience of mental illness in eighteenth century psychiatry (according to Khalfa, 2009).

By contrast, families' narratives about OD can be understood as portraying experiences of compassion, developed understanding about mental health and, for some, liberation or independence. Due to families' reports of OD being a non-hierarchical and supportive approach, in which responsibility is shared and opportunities for people to regain control over their lives are provided, OD can be perceived, as experienced by these families, as an empowering organisation (Zimmerman, 2000). Zimmerman (2000) suggests that empowered organisations are those that can offer alternative effective support, which may be extended to wider audiences. Given that families in this research have reported effective changes since OD in how they have been supportive of each other, as well as how they have communicated with their wider social network beyond OD, families can be said to have been empowered by OD. The extent to which OD was experienced as personally empowering for service-users, however, can be seen to be variable. Although it can be argued that all service-users portrayed some exertion of control over their environment, some added ability to acquire the resources they needed and some critical understanding of their social environment: these signs of personal empowerment Zimmerman (2000) were demonstrated more by some than others. These critical perspectives suggest that OD may well have had a powerful influence on how participants experience their mental health, as Foucault (1988) suggests healthcare structures have the power to do. Rather than the NHS holding onto

this power, it would seem that OD has empowered families, enabling them to be the authors of their mental health experience, having felt constricted by traditional NHS mental healthcare prior to acquiring this authorship. The extent to which empowerment was experienced by service-users and their families does appear to have variable however.

**Mental Illness as a Subjective Human Experience Related to Social Context:** Although traditional NHS mental healthcare cherishes the canonical professional narrative of ‘person-centred care’, the extent to which it prizes the individual experiences of its service-users and their relatives seems questionable, based upon what these participants told me about this care. For example, the amount of psychological therapy offered to a service-user seems to be an arbitrary allocation rather than one made in accordance with his or her needs. In this objectification of mental healthcare, the person’s subjectivity seems to get lost, as in eighteenth century psychiatry, which, according to Foucault (1988), objectified mental illness as something that needed curing, rather than understanding it as a human experience (according to Gutting’s (2010) interpretation). Furthermore, feminist theory about the process of the objectification of women (Nussbaum, 1995; Langton 2009), can be extrapolated to provide a useful, although critical, viewpoint of service-users’ experiences of mental healthcare prior to OD. Some of the concepts feminist theory uses to describe objectification are denial of autonomy, loss of ownership, denial of subjectivity, reduction to appearance and silencing (Nussbaum, 1995; Langton 2009). From this critical viewpoint, service-users’ experience of their mental health can also be perceived as having been objectified by traditional NHS mental healthcare. Like some women’s ability to resist the objectification of the female body, however, (Fredrickson & Roberts, 1997), the participants in this research have been able to subvert the objectification of mental illness through OD. Participants’ narratives of their OD experience can be seen as appreciation of an approach (OD) to understanding mental illness as a form of human experience, which can be understood by situating it within its respective social context, and by not objectifying it from a medical perspective. This seemed apparent, for example, with Laura, whose voice seemed to have been muted by her prior mental healthcare and her subsequent anger seemed to have become amplified, leading her to have little reason to believe that expressing her difficulties via OD would help. Her

family's narratives seem to argue that Laura was released from the confines of an untailored and impersonal mental healthcare experience. By listening in OD to Laura's mental health experience, and understanding it within its social context, Laura's subjectivity is recognised and restored.

## **Chapter 4: Discussion**

### **Overview**

By looking at all of the narrative themes identified across the interviews, as well as considering the two overarching critical perspectives developed in stage 5 of my analysis, I considered what seemed particularly pertinent about participants' experiences in relation to my research question. This led me to synthesise my results further by using the concepts of humanistic therapeutic relationships and compassion. From these conceptual perspectives I review my findings in relation to past research. I then discuss the applications and limitations of this research, as well as ideas for further research, before concluding.

### **Discussion**

#### **Humanistic Therapeutic Relationships**

For the purposes of this discussion, I define a 'therapeutic relationship' as an interpersonal relationship which has some form of therapeutic outcome. I have deliberately not chosen a definition that has been used in individual, group or family therapy (Norcross, 2011; Friedlander, Escudero, Heatherington, & Diamond, 2011; Burlingame, McClendon, & Alonso, 2011) because these tend to centre on the relationship with the professional or the relationships within a single group, instead of the multi-lateral relationship framework outlined above. Instead I wanted to consider the manifestation of therapeutic relationships in a family's social network more broadly. Families described therapeutic relationships as having developed with professionals in OD, but also as having developed between each other, and between them and their wider social network. Families' narratives suggested that valuable relationships have developed since OD due to a culture within OD of valuing the service-user's mental illness experience, of trusting and respecting the equally valid perspectives of everyone in the meetings, and of having adequate time to talk, in order to allow for a mutually developed understanding about the mental illness. This form of relationship seems similar to the idea of a therapist having unconditional positive regard, being authentic and expressing accurate empathy in person-centred therapy (Rogers, 1957/2007). Open dialogue is described by Razzaque (2015) as "person-centred". The indebtedness of OD to Rogerian therapy has also been observed by Stockmann (2016). Furthermore, peer-



supported OD is ascribed with humanistic and person-centred values (Razzaque & Stockmann, 2016), and it is described as a “client driven and person-centred approach” (Razzaque, Jackson, and Hopfenbeck, n.d.). I did not, however, find any comprehensive conceptualisation of the OD therapeutic relationship from a person-centred perspective. Humanistic approaches to psychotherapy focus on the capacity of people to make choices in order to reach their ‘full potential’, as well as emphasising the respect of others (“Different approaches to psychotherapy”, n.d.). One form of this is person-centred therapy, which rejects the idea that the professional is an expert on the service-user’s experience (Rogers, 1951/2003). This conceptualisation of how therapeutic change can occur through a specialised relationship corresponds with families’ narratives of therapeutic change through relationships in OD. In what follows, I incorporate a humanistic psychology perspective, using Rogers’ (1957/2007) core conditions of therapeutic change, as outlined above, in order to understand the therapeutic relationship in families’ narratives further.

**Developing Respect, Trust and Depth in Professional-User Relationships:** Interpersonal trust and respect between OD users and professionals is identified as highly important in families’ narratives. By developing trust and respect with the professionals, families described how they also developed trust and respect of the OD process. Trust seemed to develop in narratives via respectful relationships. This process was illustrated by experiences such as the service-user really feeling that professionals were there to listen to them, wanting to get to know them and vice versa, being non-judgemental with them, accepting them and compassionately validating their experiences. As well as a caring attitude, professional characteristics that seemed to be linked to these relationships in families’ narratives were a helpful attitude, being calm and being optimistic. Having choice about how to engage with OD and a sense of having more control over one’s mental illness were experiences that seemed to relate to these trusting and respectful relationships. For some families these relationships seemed to develop over just a few sessions, for others it seemed to take a lot longer, and, for others, the process of developing trust and respect seemed to be ongoing. It seems important to explore whether there are other factors that determine the development of these highly valued relationships.

Several studies cited in the literature review highlight how OD-users have described their OD experience as 'respectful' (Balleby & Søbjerger, 2012; Søbjerger & Balleby, 2012; Jensen & Jensen, 2001; Hartman and De Courcey, 2015 - all cited in Buus et al., 2017). Piippo and Aaltonen (2008) conceptualise the formation of trust in OD as being related to respect, honesty and power. The experience of empowerment and respect of the service-user's subjectivity which families described is supported by the finding of Piippo and Aaltonen (2008) that appropriate help, offered in OD in a way that did not imply that any one individual, or institution, had particular power over the knowledge of what was best for the service-user, led to participants feeling more autonomous. They also found that when professionals shared their thoughts in meetings honestly, the relationship between professionals and OD-users deepened by becoming more transparent and open mutually. It is argued that since openness, disclosure and honesty constitute the establishment of trust in a relationship (Giddens, 1991), this mutual openness in the professional-user relationship helped trust to form. Past research supports participants' portrayals of how trust and respect developed in OD through the opportunity of really getting to know the professionals, beyond their professional identities.

Unconditional positive regard (Rogers, 1957/2007) can be understood as a professional's full acceptance of all aspects of a service-user's personality, whether pleasant or unpleasant, whether judged to be 'good' or 'bad'. It implies not placing any conditions on accepting any part of someone's personality. It means caring for the service-user by permitting them to feel what they feel. It appears that unconditional positive regard is apt when trying to comprehend, at least, part of the therapeutic relationship with professionals that families described. The permission they were given to talk, or indeed to not talk, as well as the non-judgemental and accepting support they described are all suggestive of this relational factor being present. It has been identified by a meta-analysis that positive regard of a service-user has a medium effect size (0.27) in relation to psychotherapy outcomes (Farber & Doolin, 2011), suggesting that it, indeed, contributes significantly to the therapeutic relationship.

Kolden, Klein, Wang and Austin (2011) explain that congruence involves a person being mindfully aware and accepting of their self, and also the person being motivated to

engage with, and to carefully share, perceptions. They explain that Rogers understood part of the function of congruence in relationships as being to model being open to one's full experience without fearing it. As others, subsequently, become more congruent themselves, deeper more intimate relationships develop. They suggest that greater personal attunement to the service-user leads to the therapist using words that more accurately capture the service-user's experience. This therapeutic stance is resonant with one of the aims of NHS OD, viz. that professionals are aware and accepting of their thoughts and feelings in meetings (Razzaque & Stockmann, 2016). Families' narratives of service-users being truly listened to and feeling connected with professionals seem to involve descriptions of professionals acting congruently, but, more importantly, they include illustrations of the service-user becoming more self-aware and self-accepting themselves. Narratives also appeared to show that relatives became more self-aware and self-accepting of their role in caring for the service-user. Kolden et al. (2011) completed a meta-analysis of the effectiveness of congruence on psychotherapeutic outcomes, in which they identified a medium effect size (0.24), which accounted for approximately 6% of the variance in treatment outcomes, indicating that congruence also makes an important contribution to therapeutic relationships.

Although conceptually similar, empathy differs from congruence in its focus on the experience of the other and the perseverance involved in sharing respective perceptions, which are as accurate as possible (Rogers, 1957/2007). As well as professionals being open and empathic, it is suggested that service-users also need to be open in order to enable the empathic process (Barrett-Lennard, 1981; Orlinsky, Grawe, & Parks, 1994). The focus in OD on the service-user's experience, a paramount aspect of all families' narratives, may have supported this cyclical process. All of the family narratives included service-user descriptions of their mental health experience being truly appreciated by professionals. The significance of empathy in psychotherapy is supported by a meta-analysis which found that empathy had a medium effect size (0.30) and accounted for 9% of the variance in the outcome of therapy (Elliott, Bohart, Watson, & Greenberg, 2011).

Interestingly, the proportions of variance in therapy outcome that unconditional positive regard, empathy and congruence independently account for are similar to, or

more than the proportion of variance in therapy outcome attributed to the effect of the specific psychotherapeutic model used, estimated to be 1-8% (Wampold, 2001). This supports the suggestion in families' narratives that significant elements of OD include professionals being supportive, honestly communicating how they feel, and being empathic.

Rogers (1957, 2007) identified incongruence as a discrepancy between a person's experience and their perception of this experience. He explained that, when a person does not have any awareness of their incongruence, then they are vulnerable to anxiety and disorganisation, because of the increased likelihood of an unexpected experience occurring. If a person has, at least, some perception of their incongruence, then this is conceived as also resulting in anxiety or tension, due to the threat that perception poses. Being vulnerable in any of these ways is one of Rogers' necessary pre-conditions of therapeutic change in psychotherapy. The service-users who participated in my research can all be perceived as vulnerable from this perspective. If the aim of a therapeutic encounter is to help a service-user become less vulnerable, then it would seem that supporting them without in some way challenging them to change their relationship to their incongruence would be insufficient. As well as trying to empathise with and value the client or '*be with*' them, the therapist in person-centred therapy attempts to offer a separate human response, or to '*counter*' the service-user (Schmid & Mearns, 2006). One example of this occurring in practice may be through a therapist articulating how they feel about a service-user. Schmid & Mearns (2006) suggest that, by using positive regard, congruence and empathy, as well as a mutual exchange of views with a service-user in dialogue, a personal and co-created meeting at 'relational depth' (Mearns, 1996) can occur, which enables recovery from mental illness. The idea that this may be particularly pertinent, implying that what is important is a flow of honest and personal dialogue, is consistent with the findings of dialogical sequence analysis research (Seikkula, 2002; Grosås, 2010 - cited in Buus et al. 2017; Lidbom et al., 2014; 2015; Ropstad, 2010 - cited in Buus et al., 2017). By enabling co-created meaning at relational depth, the person-centred therapeutic relationship can be understood as a facilitator of such dialogue.

It is not clear, however, from families' narratives, to what extent they were met at relational depth in their dialogues with professionals. There appears to be a variance in the degree to which service-user self-understanding developed in the narratives, which may be indicative of the extent to which they were countered in a person-centred therapeutic relationship. There was also variance in the degree to which families described their relationships with professionals as personal; some identified it as caring, whilst others likened it to a friendship. The extent of this bonding may have related to how safe the relationship felt and, therefore, how comfortable professionals were with challenging service-users. Rogers (1967/2004) suggests that the more a therapist is able to let down their guard of professional processes with the service-user and be the vulnerable person they are behind this, the more the relationship can be used for therapeutic gain. It seems possible that, if there was a difference in relational depth across families' experiences, at least part of this may be due to individual differences in the extent to which professionals were able to do this, in the way Rogers describes. It would seem that relational depth in families' experiences of OD was founded upon trust and respect, as well as mutual openness between professionals and OD-users. The concept of relational depth helps to unify Rogers' core conditions of therapeutic change and how this may relate to families' experiences of therapeutic relationships developing in OD. Further research could help clarify the relationship depth of families' relationships with professionals and how these function.

**Enhancing Relationships Systemically:** The therapeutic relationships with professionals which families developed in OD appeared to be related to families, also, enhancing their relationships with each other and with others in their social network. For some, these therapeutic relationships seemed to provide a model of how they could safely engage in dialogue about the mental illness with others, which they could then use to strengthen the level of support within their social network. For others, the relationships with professionals provided a safe space in which their other relationships could be reflected upon. Trust and respect were not only portrayed within families' narratives as something developed between them and professionals, but, also, as having developed within family relationships, social network relationships and, furthermore, in the treatment approach itself. This finding is supported by Piippo & Aaltonen (2008), who suggested that a culture of respecting each OD meeting attendee's expertise led to

'horizontal expertise' (Aaltonen et al., 2000 – cited in Piippo & Aaltonen, 2008), which led to openness and trust within the whole treatment system, rather than on an individual level. Similarly, power sharing and deep respect of the value of each person's perspective in families' narratives appeared to be a key catalyst in the systemic development of therapeutic relationships and trust in the OD approach. From a person-centred perspective, this could be understood as the power of unconditional positive regard of each other's experience.

The idea that congruent relationships are spread via modelling (Rogers, n.d. - cited in Kolden et al., 2011), provides a useful perspective for considering how therapeutic relationships, within the narratives, seem to have developed across the social networks of the families. Having been more congruent, or open with each other, within OD meetings, families described how this had led them on to becoming more open with others in their social networks. If these more open relationships are beneficial, perhaps due to their more intimate and supportive nature, then social cognitive theory (Bandura, 1986) would suggest that they would continue spreading. On this basis, it may be that, in the future, families' narratives of OD will include an even wider spread of congruency in social network relationships as modelling perpetuates its development. Perhaps, this is what has led to the increased public receptivity of mental healthcare in Finland (Seikkula et al., 2011).

Families' narratives also highly valued the empathy that they developed with each other, as well as the empathy that they received from other family and/or social network members. As particularly portrayed by Laura, Jerry and Vivienne, some families described the opportunity they had to learn from each other about the mental health issue via empathic relationships in meetings. It seemed plausible that different interpersonal relationships within families would showcase different empathic styles. Posture, words used, frequency and position of talk have all been shown to be moderating factors in empathy between service-users and professionals (Duan & Hill, 1996; Watson, 2001). Research shows that choosing the appropriate quantity and quality of empathy can make it more suited to the individual service-user's vulnerability (Kennedy-Moore & Watson, 1999). Could it be that part of the empathy families felt was related to both professionals and family members learning from each other how best to

empathise with each other, as social cognitive theory (Bandura, 1986) would suggest is possible?

Linehan (1997) differentiates empathy from validation by explaining that validation not only involves empathy, but it also involves implicitly answering “yes” to the service-user’s implicit existential question of “can my experience be true?” As well as validating a person’s past and present experience and behaviour, validation she explains can include a therapeutic stance which assumes the future validity of a person, rather than taking them a priori as incapacitated or disabled. The overarching process of relationship development within families’ narratives could be said to be related to a communal pursuit of validating the service-user’s experience. For Mary, Laura and Sheila this process seems to have empowered them to take more ownership over their subjectivity in relation to their mental illness. By sharing this with others outside of OD meetings they have been able to help others to understand this important part of their identity, as well as giving themselves further opportunity for even greater validation. By having these experiences accepted by others these service-users seem to be discovering that their mental illness is not as socially prohibitive as they had perhaps once suspected, and that they are less incapacitated by it, as Linehan (1997) suggests is possible with validating experiences.

For Dave and Alfred, their experiences were also validated within their respective family narratives, but this validation appears to have happened mostly within OD meetings. It seems possible that they did not feel as empowered as Mary, Laura and Sheila to share their experience of mental illness beyond OD meetings. The discord within Dave’s family and the general difficulty Alfred has with social interaction are parts of their respective narratives that may help explain this. It would seem that Sharon and Jennifer are Dave and Alfred’s respective key source of validating relationship beyond OD meetings, and that the opportunity for other such relationships had not as yet developed as much as it had for Mary, Laura and Sheila. What may also be indicated here is how OD affects genders differently. The humanistic therapeutic relationship available within meetings can however be seen as having helped all the service-users I interviewed to feel more validated.

Families' narratives also identified the significance of relatives' experiences of caring being validated within OD meetings, by giving them an experience of feeling supported themselves. By sharing their experiences of caring for their mentally unwell relative, they were empowered to be more self-affirming, to amend their care approach where suitable, and, perhaps, to share their care experiences with others beyond OD, in order to continue this process of validation. Crucial to all the narratives I analysed seemed to be having a safe and private place within OD meetings, in which to begin nurturing first and foremost the service-users', but also of significant importance within some narratives, the relatives' experiences as acceptable, understandable and, therefore, validating of who they are and who they might become.

Two families described their relationships with professionals as akin to friendships. Rogers & Traux (1967) describe a therapist coming into direct contact with their client without pretence; Safran and Segal (1990) describe a therapist transcending their professional role to facilitate human relatedness as available for healing. It is, perhaps, the opportunity for relationships which present in such a natural way as this (Linehan, 1997) with trust, respect, and the non-romantic and non-sexual love (Seikkula & Trimble, 2005) akin to friendship, that provide the foundation for validation, as illustrated in families' narratives, both within OD meetings and in-between them. These validating relationships may have led families feel that their mental illness experiences might also be validated by others, in such relationships, in their wider social networks. The person-centred relational position provides one way of understanding how such valuable depth in relationships became more possible within meetings and for families beyond meetings.

**Finding the Most Comfortable Interpersonal Dynamic in Meetings:** In person-centred therapy the hope is that, by providing the core conditions as described above, the service-user can learn to be more accepting of their difficulties, and, thereby, they can learn how they can respond to these in a way that will enable them to reach their best potential (Mearns & Thorne, 2013). The anxiety that some participants expressed in their narratives about which family members to include in meetings can, perhaps, be conceived as them trying to attain, or maintain, the right conditions or environment for their growth, so that they can more easily access and use this inner valuing process.



Person-centred therapy suggests that service-users tend to have external loci of self-evaluation, such as the critical viewpoints of others (Mearns & Thorne, 2013). Excluding critical relatives, for example, could be understood as a way of a participant acting to prevent their critical self-judgement being reinforced by denigrating others.

Participants were either concerned about feeling overwhelmed if they were to invite multiple or particular family members into meetings, or about upsetting family members within meetings. Past research has identified OD user ambiguity about their roles within OD and about the processes involved in the approach (Holloway, 2009; Johansen & Bille, 2005 - both cited in Buus et al., 2017; Gordon et al., 2016). It seemed that such ambiguity may also have contributed to the anxiety families portrayed about the consequences of involving other relatives in meetings. Piippo and Aaltonen (2004) support the finding that service-users were concerned about upsetting their family members by inviting them to a meeting. The main factor seemed to be discomfort due to discordant relationships within families.

What seems to be helpful in interpersonal trauma therapy is the development of trust in the therapy relationship, so that service-users can discuss their traumatic histories (Sandberg, Gustafsson and Holmqvist, 2017). This need for security could provide useful insight into the choices families made about whom to include in OD meetings. Byng-Hall (1995) uses attachment theory (Ainsworth et al., 1978; Bowlby, 1979; 1988) to conceptualise the family's need in systemic therapy for a secure base to be established before it can explore new psychological ground. The diversity in participants' relationship dynamics, let alone the relationship dynamics within an OD meeting, seems likely to mean that the form of secure base in regard to who was included in a meeting will have varied from family to family. It also seems likely that establishing what feels like a secure systemic base in OD will take time, in order for the possible and preferable configurations to be considered by the service-user and/or their family members. Until trust and a secure base had been developed in OD, families may have felt uncertain about their safety and anxious.

Alfred and Jennifer highlighted another developmental issue that may have contributed to anxiety about OD for the service-user in particular, viz. having an autism spectrum

disorder (ASD). Although research does show that young people with ASD can benefit from group therapeutic interventions (Reichow, Steiner, & Volkmar, 2013), I did not find any research on the interaction of ASD with OD. Since people with ASD may have difficulties with social interaction, it seemed understandable that a group approach like OD was overwhelming for Alfred at times. Piippo and Aaltonen (2004) found that one negative aspect of OD for some of its users was that discussion in meetings felt too abstracted from their life, and, therefore, reminded the service-user of their sense of social isolation. It seems that such abstraction could be particularly problematic for service-users with a developmental disorder that significantly affects their general ability to understand social interaction. There could be a danger, therefore, that OD could be re-traumatising for such service-users. Although Ponnet, Buysse, Roeyers, and De Corte (2005) found that adults with a pervasive developmental disorder (such as ASD) were no less able to understand communication in a short unstructured conversation than typically developing individuals, the authors suggested that knowledge of common schematic conversation scripts and the implicit structural framework of the conversation within the experiment, may have aided the participants. This suggests that people with developmental disorders like Asperger's Syndrome, may be able to engage effectively with the social interaction within OD, like Alfred did, but that the unstructured and unscripted flow of conversation in OD may require adaptation to make engagement more effective and, possibly, less anxiety-provoking for such individuals.

**Having Enough Time:** In person-centred therapy, it is ultimately up to the service-user to decide when to end the therapy; this approach is justified on the grounds that their felt need for the therapeutic relationship is not otherwise invalidated by an arbitrary maximum amount of therapy on offer (Mearns & Thorne, 2013). Within each of the family narratives, the fundamental importance of having enough time to discuss the mental illness in their family was included. Service-users, in particular, explained that, in contrast to their prior mental healthcare, they were not restricted by time, which enabled them to explore their experience, or to listen to others reflect on their mental illness, at their own pace. This finding concurs with US OD service-users' reports of feeling unrestricted by time (Gordon et al., 2016). These findings suggest that the unrestricted timeframe of OD constituted a part of the context in which therapeutic relationships could be established. The importance of time in treating complex mental

illness can be considered by taking account of contemporary research, which compares the benefits of long-term psychodynamic therapy with short-term psychotherapy of various modalities. The Helsinki Psychotherapy Study compared outcomes of 326 outpatients suffering from mood or anxiety disorders. It found that those with more severe mental illnesses benefitted more from individual longer-term psychodynamic psychotherapy (three years) than individual short-term psychotherapy (six months) (Laaksonen, Knekt & Lindfors, 2013). This finding is supported by a meta-analysis of such studies (Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013). The benefit of longer-term (80 weeks) over shorter-term psychotherapy (20 weeks) has also been found in group psychodynamic psychotherapy settings, in a sample of 167 outpatients with mood, anxiety and personality disorders (Lorentzen, Ruud, Fjeltstad and Hoglend, 2013). Lorentzen et al. (2015) identified service-users with higher self-denigrating tendencies to benefit more from longer-term group psychotherapy. Although caution needs to be taken about the validity of applying these findings to the different modality of OD, they suggest that consideration of both the complexity and quality of a service-user's mental illness may be important when deciding upon the optimal length of OD for them. The suggestion that more complex presentations may require a longer duration of therapy is consistent with both the complexity of families' difficulties in my sample, and their appreciation of having enough time in OD.

Of further relevance to considering the importance of time in OD is research from the Helsinki Psychotherapy Study which suggests that social factors may interact with the length of psychotherapy offered. Patients with a poor socio-demographic status, such as a low education level were less able to benefit from shorter-term psychotherapy and needed longer-term psychotherapy to benefit (Joutsenniemi, Laaksonen, Knekt, Haaramo & Lindfors, 2012). Being socially supported is defined by Chronister, Johnson, and Berven (2006) as feeling cared for, connected to others and feeling respected. Interestingly, patients with low social support benefitted from short-term psychotherapy and no additional benefit was identified with longer-term psychotherapy (Lindfors, Ojanen, Jääskeläinen & Knekt, 2014). This suggests that psychotherapy only offers limited benefits to those with, otherwise, low social support. The usefulness of having more time in OD, therefore, may depend upon the quality of the resources a person has in their social network and their particular social support needs. Although all

the families whom I interviewed valued having unlimited time in OD, how much time would be optimal for their needs and what other social support they may need is unknown. These issues seem pertinent and call for further enquiry.

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Families seemed to be in need of a trustworthy and secure interpersonal foundation, in order for them to explore their mental illness concerns in OD. From a person-centred therapy perspective, families can be identified in their narratives as having demonstrated their individual needs for particular conditions for psychological growth, as well as how these needs were accommodated by the flexible OD approach and humanistic therapeutic relationships.

#### Facing the Unknown With Compassion

Open dialogue users compassionately accepting themselves and others can be considered as an attitude encouraged by humanistic therapeutic relationships, which further enabled families to share their experiences and to learn how to best cope with mental illness, despite the ambiguity and anxiety they faced in OD. Neff (2003) identifies compassion as involving kindness, common humanity and mindful acceptance. 'Kindness' refers to being kind and warm towards one's difficulties, rather than harshly self-critical. 'Common humanity' refers to understanding one's difficulties as being related to the human condition, rather than as something that is isolated from this and as something of which to be ashamed. 'Mindful acceptance' involves being aware of one's difficult thoughts and feelings with acceptance of their presence, rather than necessarily incorporating them into one's identity. Within families' narratives, dialogue about the service-user's mental illness experience gradually developed, which for the service-user tended to lead to a kind acceptance of their experience, rather than an attempt to hide it from others due to uncertainty or fear about what might happen if it was shared. This anxiety about sharing one's experience seems to have been related to a general mistrust of mental healthcare and the novelty of OD. For some participants, accepting their experience themselves and having others accept it too seemed to be the key comforting factors, for others, these factors seemed to act as a catalyst for them to go on to try and develop their understanding of their mental illness further. Seikkula and

Trimble (2005) encourages OD professionals to listen to OD users with intent and compassion. Razzaque and Stockmann (2016) emphasise the importance of professionals being mindfully aware, accepting and compassionate when working with OD users. I am not aware of any literature however, which explores how compassion is experienced by OD users. I first discuss the uncertain prospect of OD and how this seemed to have been anxiety-provoking for participants. Then, I will argue that compassion in OD appears to have helped families to tolerate this anxiety and to explore what recovery might mean to them.

**The Uncertainty of Open Dialogue:** Anxiety in OD seemed to have at least partially developed from users' uncertainty about the roles and process of OD. Piippo and Aaltonen (2008) suggested that where the OD model is used insistently by professionals, knowledge generation can stagnate. They found that, in situations where uncertainty existed about who had the power to make decisions in OD meetings, it defaulted to the professionals to make the decisions and OD-users losing autonomy. In such situations where the OD user loses their autonomy it is suggested that they become more distrustful of OD. Where the OD user was able to give feedback about the OD process, however, it was found that autonomy can be regained. Given the uncertainty the families I interviewed had about the OD process at times, as well as their vulnerabilities, I wonder if they felt that they could challenge the process. It seemed possible that families may have experienced the enthusiasm of their OD professionals as overbearing, leading them to feel unsure about how they might effectively use OD meetings. Part of their anxiety about OD may have been related to a fear of again losing autonomy in an unfamiliar mental healthcare approach, in which they might feel disempowered.

Calsyn, Winter, and Morse (2000) suggest that service-users having treatment choice may be good for service-user engagement and treatment outcomes for high functioning service-users, but for SMI service-users, outcomes do not seem to be related to having treatment choice. Shared decision making, rather than either professionals or service-users making treatment decisions, has been found to be selected as preferable by inpatient SMI service-users in the US (Hamann, Cohen, Leucht, Busch, and Kissling, 2005) and by community SMI service-users in the UK (Hill & Laugharne, 2006). It would seem that, for the families I interviewed, as well as the threat of a return of hierarchy in

uncertain moments in the OD process, there may also have been the threat of a disjointed approach, where the service-user and, perhaps, their family wanted a more collaborative approach with professionals and the opportunity for shared decision making, but that this was lacking. Although families did not express this wish in their narratives, they did express confusion in their narratives at times when the usual professional structure, to which they were accustomed, was absent. Perhaps, part of the families' anxiety was due to the uncertainty about the roles and responsibilities of each OD meeting attendee.

The finding that families experienced uncertainty about the OD process is corroborated by research on families' or social network members' experiences of OD in other countries (Holloway, 2009; Johansen & Bille, 2005 – both cited in Buus et al. 2017; Gordon et al., 2016). Although tolerating uncertainty is a principle of OD (Seikkula et al., 2003) and the ambiguity reported by families may have been related to professionals' abiding by this principle, it is unclear from my research whether families knew this, or, if they were aware of this aspect of OD, whether this awareness reassured them. Shihata, McEoy and Mullan (2017) argue that intolerance of uncertainty is not only a transdiagnostic aspect of anxiety disorders, but it is also a trait that can make a person more vulnerable to anxiety. Although this may not have been a problem for all participants, given the diagnoses service-users reported having been given, it would seem that it may have been for, at least, some of them, and, possibly, a symptom or trait for some of the other participants. Qualitative questionnaire responses from 166 mental healthcare service-users with enduring mental health difficulties, mostly with a diagnosis of schizophrenia, and 28 social network members in Wales, identified that both service-users and social network members had many uncertainties about the mental healthcare they had been given (Rapport et al., 2010). Social network members wanted to know more about the treatment and they expressed anxiety about the welfare of the service-user they cared for, as well as about their own welfare. Service-users reported feeling unsupported by mental health services and unable to access detailed mental health information through professionals. It seems quite possible that the participants interviewed in this research had many such queries due to their reports of insufficient past mental healthcare, as well as the new and unknown OD approach. This may have meant that they were anxious about mental healthcare in general before

engaging in the novel and unknown process of OD. Given that this may have been the case and the propensity of uncertainty to lead to anxiety for both service-users and family members, it seems that OD may need to do more to support families with their uncertainties about OD treatment, at least initially. Indeed two OD-users at the 2017 National Peer-Supported Open Dialogue Conference reported to the conference that they would have liked to have had more information about the OD process before engaging in it.

It seemed that mistrust of dialogue with mental health professionals existed in various forms within the families prior to their engagement with OD. This seemed to be related to disempowering and objectifying/depersonalising experiences of traditional NHS mental healthcare. Piippo and Aaltonen (2008) identified that mistrust of treatment before OD was related to professionals being inflexible in their understanding about the mental health issue and unwilling to discuss this with a service-user, the service-user feeling that they were being treated in a depersonalised way and that they were being excluded from decision making. Consequently, the service-user identified remaining confused about their situation. Though this research is based on Swedish mental healthcare, the experiences it ascribes to 'mistrust' are similar to those reported by the families I interviewed. The non-collaborative and hierarchical process just outlined, which does not seem to promote service-users using their own resources, can be considered as disempowering, when contrasted with Dunst, Trivette, and LaPointe's (1994) description of empowerment as a collaborative approach, focused on the service-user's strengths. Indeed, the naïve resultant state of service-users could be described as disempowered (Zimmerman, 2000). The preference service-users show for a collaborative rather than a didactic approach to mental healthcare is further supported by a study that found that 82% of NHS service-user participants who had collaborated in the creation of their care plan reported that the care plan had had a positive impact on their lives, in contrast to 12% of those who had not been involved in a collaborative approach (Peck, Gulliver & Towel, 2002). In respect of doctor-patient relationships in the UK and US, the patient having control over treatment, along with there being more time to develop a doctor-patient relationship has been found to lead to patient trust (Blendon, Brodie, & Benson, 1998; Mainous, Baker, Love, Gray, and Gill, 2001; Kao, Green, and Davies, 1998). Interviews with 34 service-users with SMI demonstrated that

trust is an important aspect of developing positive therapeutic relationships (Balkrishnan, Dugan, and Camacho, 2003). It seems that the families whom I interviewed had not had very much opportunity in their prior mental healthcare experience to be empowered with choice and trust, or with collaborative and therapeutic relationships. This perspective may have predisposed participants to mistrust OD.

**Compassion as a Part of the Journey of Recovery:** Recovery in mental healthcare has been described as a personal journey of discovery (Repper & Perkins, 2012). “It involves making sense of, and finding meaning in what has happened, becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities and using these, and the resources available to you, to pursue your aspirations and goals” (Perkins, Repper, Rinaldi, and Brown, 2012). It is about encouraging people to have hope, control and opportunity in their lives (Repper & Perkins, 2003). It has been argued, however, that the focus on individuals taking journeys of recovery can neglect the social injustice that may prevent a person from recovering, which thereby further disempowers the person wishing to recover (Speed and Harper, 2015). By focusing on strengths and resources in recovery, Boyle (2003) argues that weaknesses are implied within individuals, which again neglects socially causative factors of distress. I therefore used O’Hagan’s (2002/n.d.) broad definition of recovery to consider both the individual and social aspects of recovery discussed above: “the individual and social processes that ensure people with ongoing or episodic mental health problems can live well”. Although recovery was an aspect in each of the family narratives, the quality in which it manifested varied.

By sharing their mental illness experiences within OD meetings, families allowed each other to develop a more mutual understanding of the illness, as was found by Piippo & Aaltonen (2008; 2009). Subsequently, they described situations in which they had adapted their lives to cope more effectively with the illness, as was found by Brottveit (2002 - cited in Buus et al., 2017) and by Settem (2008 - cited in Buus et al., 2017). The compassion between professionals and users, and within families seemed an important part of the development of this dialogue. Rather than being afraid of, or anxious about, being repudiated for sharing their experience of mental illness, service-users expressed kindness and mindful acceptance of their mental illness. By having their experiences



accepted and understood empathically within OD meetings, service-users' experiences were recognised as a part of the human condition. Family members can also be seen in their narratives to be kindly accepting of and, unreservedly, willing to share their experiences in caring for the service-user. Bøe et al.'s (2015) theory that meaning develops in dialogue because of the ethic of attending to and valuing others supports these findings.

Research suggests that what is necessary for meaningful understanding about the mental illness to develop in OD is emotional dialogue. Rather than the service-user's personal insight or understanding, as discussed objectively and divorced from its inherent emotion, being the important factor related to change in OD, Brottveit (2013 - cited in Buus et al., 2017) suggests that emotional disclosure within the social network in meetings is key. Meaningful change in OD is also considered to happen during exchanges of dialogue in which contributors are simultaneously experiencing inner dialogues (Ropstad, 2010; Grosås, 2010; both cited in Buus et al., 2017, and Lidbom et al., 2014; 2015). Acceptance of how mental illness affects the service-user and family seemed to be the key component of meaningful understanding in OD for some families, whereas for others, understanding mental illness seemed to be associated with a more extended exploration into past experiences. Although it was unclear from the narratives I analysed in which way such understanding about mental illness in OD developed, a compassionate attitude, fostered by humanistic therapeutic relationships, seemed to make the emotional exchange of dialogue possible.

Perkins (2015) criticises the 'insight' prized by professionals for its devaluation of perspectives that do not fit within healthcare models. The understandings that service-users developed by thinking about their past seemed to evolve organically from the discussion in OD meetings, rather than according to any healthcare model. In Mary and George's narrative they subverted the pessimistic understanding of recovery, that recovery was supposedly limited due to mental illness being biologically predetermined, that they had been encouraged to believe by their prior mental healthcare; Instead, they adopted an optimistic understanding that recovery had become possible by understanding the effects of Mary's past compassionately (by relating her mental illness to the human condition) and by having supportive professional and social relationships.

Indeed, the pathologising tendencies of the medical model of mental illness have been reported by service-users to be damaging, with preference expressed for a more social understanding of mental distress (Beresford, Nettle & Perring, 2009). Beresford (2015) argues that British neoliberal society cuts back the role of the state and encourages people to be independent, which concords with a medical model which tends to focus on individualising people's experience. Rather than taking their history into account, the medical model reduces social problems to individual problems, which does nothing to address the social inequality and injustice with which mental distress is situated. The medical model can be understood as separating mental illness from the human condition. Although some service-users felt unable to involve family members in OD, the social-network orientation of the approach could have contributed to participants' social perspectives when it came to thinking about their understanding of their mental illness. By relating their experiences to the human condition compassionately, it seems that families may have had more opportunity in OD than a medically orientated model to kindly and mindfully accept their difficulties. Within all the family narratives, the development of understanding about their mental illness concern seemed to be unfinished and ongoing. The multitude of important historical and current factors to consider before discharging someone with SMI from a community mental health team, as shown by Colbert & Bining (2015), supports the implication of these narratives that each person's history (Beresford, 2015) and current situation needs time and space to be comprehended, both by professionals, service-users and, where possible, their family or social network members.

**Compassion and Independence:** In all of the narratives, families portrayed their experiences of feeling compassionately supported by the OD process; users feeling support was also found by previous OD research (Balleby & Søjberg, 2012; Søjberg & Balleby, 2012; both cited in Buus et al. 2017, and Gordon et al., 2016). For some families, this increased sense of support was also felt from their wider social network, as was found by Brottveit (2002 - cited in Buus et al. 2017), but, for others, the meeting attendees were the key source of support. Within some narratives, the subsequent sense of autonomy took the form of OD users feeling more able to talk openly within meetings, and in other narratives, it took the form of the family appearing to become

less reliant on NHS mental healthcare. The finding of autonomy via the empowering process of dialogue in meetings is supported by the findings of Piippo & Aaltonen (2008).

Unlike the findings of Seikkula et al. (2003; 2006; 2011), only one of the family narratives included description of the service-user having subsequently returned to work or education. To what degree this is a valid indicator of having been adequately supported and having gained independence in OD in a sample of adults with enduring and complex mental health difficulties seems questionable, given the other forms of compassionate support and empowerment families described. Furthermore, as discussed in the literature review, the efficient working relationship between mental health and employment services in Finland may not be reflected in other countries (Olson, 2015), such as the UK, so it may not be valid to compare OD outcomes on this basis.

Feeling supported and developing independence appear to be interrelated experiences within families' narratives. By being able to safely observe their own mind in the compassionate environment of OD, service-users appear to have gained some intrapsychic independence from the distress of their mental illness by achieving mindful acceptance. The trust, mutual respect or 'horizontal expertise' (Aaltonen, Ahonen, Koffert, and Lehtinen, 2001 - cited in Piippo and Aaltonen, 2008), portrayed in families' narratives seems to have led them to feeling more supported by OD and, for some, their social network. The systemic 'secure base' that OD meetings may represent for families (Byng-Hall, 1995) may have enabled them to explore their experiences safely, thereby enabling them to learn more about how best to support each other, and therefore, for some families, reducing their dependency on NHS mental healthcare. This seemed to lead on to families either sharing their related experiences with others in-between meetings, or trying new approaches to caring for each other. For those who were able to confide more in others beyond OD meetings, it appeared that they had also become less reliant on OD. Perhaps the involvement of others reduced a sense of social isolation, as was found by Thylstrup (2009 - cited in Buus et al. 2017), which may have been an issue stemming from families being unable to discuss their mental illness prior to attending OD. For other families, however, their need for OD appeared to be ongoing. As well, perhaps, as the need for time and the different needs of different SMI service-users (Colbert & Bining, 2015), the degree of compassion available from their wider

family or social network appeared from families' narratives to influence this variation in independence from OD.

The concepts of epistemic trust and mentalization (Fonagy & Allison, 2014) offer one way of understanding how individual and social differences within families and social networks may account for the variation in dependency on OD, as depicted across the family narratives. Trust in being able to learn valuable things from one's social environment (epistemic trust) is argued, by these authors, to be related to how secure one's early attachment relationships were. The capacity a person has for social engagement is considered to be related to their capacity to understand their self and others in social situations (mentalization) (Fonagy & Allison, 2014). These authors propose that helping a service-user to mentalize can help them to develop epistemic trust. Open dialogue can be considered as an approach that implicitly encourages mentalization and epistemic trust with its compassionate culture and therapeutic relationships, but, as Fonagy and Allison (2014) point out, the effectiveness of mentalization-based therapeutic approaches will depend upon the service-user's opportunity for ongoing benign relationships in their social network, in which they can continue to mentalize and develop epistemic trust. This theoretical understanding of trust and learning suggests that, for families or service-users with less availability of benign relationships, they may be more reliant on OD for this kind of ongoing support. The degree to which OD can help its users foster such supportive network dynamics beyond OD, to enable them to become independent of OD, is a point of contention in need of further research. It would seem that attempts to cultivate compassion in social networks could be particularly helpful.

Although families told me that OD would be available for them indefinitely, the future provision of OD is uncertain, given its limited evidence-base and its recent introduction into the NHS on a trial basis. In any case, limited NHS resources could mean that professionals have to decide to which families they continue offering OD and which they discharge. Furthermore, OD may come to an end because its users may decide that it is no longer appropriate for them. Where in the family's journey of recovery either party might decide OD is no longer necessary is an interesting question. All of the family narratives suggested that recovery for them was ongoing and that it still included OD.

Of significance, in spite of the uncertain availability of OD and of their ongoing need for OD, the family narratives seemed to portray personalised and empowered journeys of discovery, rather than having the canonical NHS narrative of 'recovery' told to them, as if recovery is something that is done to a person (Perkins & Slade, 2012). Mary's claim that her life was saved by OD seems not only a literal statement, but a metaphor of her improved quality of life since OD. This statement seems emblematic of the wide spectrum of improvements in the quality of families' lives they reported having experienced since OD. Rather than 'recovering from deficits', it seems families' narratives more accurately fit into the more holistic genre of 'recovering a life' (Perkins, 2015), of which compassion plays a central role. From this perspective, OD seems to be one of many parts of families' ongoing recovery journeys. The significance of this part appeared to vary between narratives, according to where each family was on their journey.

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It is argued that a human rights based approach to recovery offers a particularly liberating and empowering framework for recovery (Perkins, 2015). Instead of perpetuating isolation and segregation with individualised treatment, the empowering, democratic and social approach of OD, which compassionately relates to mental illness, can be identified as supporting service-users' rights to equality, control, and independence. Perkins (2015) emphasises that these rights, for people with disabilities, have been published by the United Nations (2006). By being supported as people with rights, it seems that service-users and their families have taken their recovery into their own hands and that it was their decision about the degree to which they would lead their lives independently of OD. The question remains, however, in regard to whether the wider society will help facilitate this recovery (Beresford, 2015; Perkins 2015), including whether OD will always be there to offer its support. The implicit overarching question here is "how sustainable is the support of OD?" Given that not all service-users, or families, have immediately available support networks and that OD was created for crisis situations, rather than enduring mental illness situations, what needs to be considered is whether OD will be available to play a sustainable, positive and meaningful role in these families' recovery journeys. If the conceptions in this discussion are

accepted as valid, discussion moves to what needs to be done to ensure the availability of OD in mental health services and social networks more widely.

### **Applications, Limitations and Future Research**

In this section I will discuss the particular applications of this research, its limitations and ideas for future research. The argument I make about the value of having produced research on NHS service-user experience is based upon two assertions about the general value of service-user experience research. The first is that understanding service-user experience is valued by NICE (2011) as a method of improving mental healthcare standards. Indeed, including service-users' experience in the design of outcome measures, which determine the funding of services, has recently been recommended (Mental Health Taskforce, 2016). This would bring service-user experience to the very forefront of how NHS services are commissioned. As important as payment by results may, therefore, be funding based on service-user experience. The second assertion is that, by helping the voices of these service-users and their families be heard via this research, I hope, by this research to encourage the further development of OD, thereby respecting the rights of service-users to equal participation in society and control over the support that they receive (United Nations, 2006).

#### **Applications to OD**

For professionals who are practicing OD, the findings may offer additional information about what OD users are experiencing, with whom they are working. Caution, however, must be taken by professionals as this research only claims to understand the experiences of the families that participated in it. The descriptive data may help professionals working in similar NHS settings to think about their OD practice however, and what questions may need to be asked in order to understand it more.

Prospective OD users may be able to use the findings of this research to make a more informed choice about whether to participate in OD. However, caution needs to be taken about using the research in this way, as they do not claim to explain what factors predict particular OD experiences in all SMIs. Those with OD experience may find it useful that I have analysed each individual family separately as this may enable them to select the analysis to which they can most relate. By relating their experiences to those

of the participants' in this study, these readers may deepen their understanding of their own OD experience, which may lead to them subsequently tailoring the illness narratives that they may be living their lives by (Frank, 2010).

### Applications to Counselling Psychology

It seems that humanistic therapeutic relationships can be usefully adopted within multidisciplinary teams and families supporting or living with SMI. Given that the humanistic relationship is often a cornerstone of the professional identity of counselling psychologists, this research raises the question of how counselling psychologists could support professionals and users to optimise their use of this relationship within and beyond OD. Counselling psychologists may be well placed to offer consultation, supervision, or training for OD professionals interested in adapting their use of therapeutic relationships in OD. Counselling psychologists may also be interested in using a qualitative approach to research how OD professionals, who do not usually prize humanistic therapeutic relationships so much, experience integrating these relationships into their professional identities in OD. It has been found by professionals in Norway that, although some aspects of developing therapeutic relationships may be a challenge for those who are not psychological therapists, they are able to integrate them into their professional role to further develop their therapeutic skills (Holmesland, 2015). Counselling psychologists may wish to explore how their skills in psychological assessment and psychological therapy may be beneficial for OD users facing anxiety in OD. They might consider offering family therapy or individual therapy to OD users as an adjunct to OD, in order to try and help facilitate therapeutic relationships within OD meetings, the family and their wider social network. This may lead to individuals and social network members engaging more with OD, which might make OD more beneficial for all the users involved.

Given the variation between counselling psychology training courses in the extent to which they focus on humanistic approaches, as well as the service policies which shape counselling psychology practice, there is likely to be variation in how much counselling psychologists integrate person-centred therapy into their work. This research suggests that counselling psychologists who work with SMI may wish to consider whether the therapeutic relationships they and their team offer could benefit from becoming more

humanistic. The value of using person-centred therapy with a broad range of SMIs is also supported by two contemporary books which demonstrate theory, practice and research of person-centred therapy with SMIs (Pearce and Sommerbeck, 2014; Joseph 2017). As with the NHS, counselling psychology training tends to focus on offering psychological therapy to individuals rather than families. The value of including an SMI service-user's family in their mental healthcare, as demonstrated by this research, may lead counselling psychologists who work with SMIs to consider integrating more of a systemic approach into their work. Understanding mental health difficulties in relation to the human condition concords with counselling psychology's core value of trying to understand a person in relation to their context, rather than by focusing on their individual pathology (Steffen, Vossler & Joseph, 2015). Systemic practice that helps develop compassion in social networks is well suited to counselling psychology values therefore.

More generally, counselling psychologists who work with service-users and/or their relatives may find it useful to consider how service-users may have been affected by their prior mental healthcare, based upon the experiences portrayed by the families in this study. This research may highlight how these experiences can disempower people, leaving them with little hope of recovery. Counselling psychologists may benefit from working with a more compassion-based approach when working with these people, in order to validate their experiences and empower them to take back ownership of their recovery journey. Counselling psychologists may find it useful to develop psychological formulations and interventions based on the conception of compassion I have used in this research.

### The Limitations of This Study

As has already been raised in the section above, this research does not claim to offer knowledge about the experiences of OD users who did not participate in this study. Although I engaged in a critical analysis of my own subjectivity as a researcher, in order to open up my perspective on families' narratives, Ricoeur (1996) explains that there is always a position from which we have a view; the knowledge produced by this research was therefore influenced by my unique perspective. Other researchers may well generate different knowledge from the data I collected, so the findings I present are



most validly considered within this epistemological framework. The qualitative approach taken was however useful for the purpose of developing understanding about the OD experiences of the families I interviewed. By taking an idiographic and exploratory approach, I have opened up several avenues of enquiry that further research may wish to explore.

The sample in this research was heterogeneous with respect to mental illness, developmental disorder, age, the type of relative/s who participated with the service-user, and the length of time that families had been having OD. There has, therefore, been less opportunity for discussion about the findings in relation to homogenous aspects of the sample. The wide range of pertinent questions that this diverse sample has raised, however, has been suitable for the broad aims of this research. As well as, hopefully, broadening future enquiry into OD, I hope that my synthesis and discussion offers ways of conceiving of more common experiences that may be worthy of future research. There was one homogenous demographic worthy of note however; every family classed their ethnicity as 'White-British'. This raises the question of whether families who identify as other ethnicities would tell different narratives about their OD experience.

Experience with my first family, identified the fact that narratives did actually 'emerge' and that I did not need to use my schedule so strictly in order to facilitate their emergence. My anxiety in this first interview about ensuring my areas of interest were covered meant that I felt the need to cover each main question, whereas I believe this family would have covered these topics without me interrupting the flow of their narrative. By relinquishing this control in the subsequent interviews, and only asking questions where the topic area had not been covered (Langdridge, 2007), I believe I empowered families to tell me their stories, as Riessman (2008) suggested: this is possible with an open such approach to narrative interviewing. Perhaps, because of the practice that the families had effectively had in telling their story by engaging with OD, key difficulties that they may have otherwise had in relation to doing this had already been, at least, partially overcome. Riessman (2008) suggests that listening to participants tell traumatic stories often evokes vulnerabilities in the listener. I believe that my professional experience of working with people with SMI and my counselling

psychology training contributed to my ability to listen attentively to families' narratives, without being too distracted by my own vulnerabilities when I was affected by the stories I was hearing. Although my initial use of an interview schedule had less qualities of narrative interviewing (Riessman, 2008; Langdridge, 2007), I believe I was able to adapt this suitably to enable the remaining families to co-construct their narratives of experience.

Could another method of data analysis have helped me achieve my aims and, if so, how does the method I have used limit my findings? Interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) would be suited to my aim of exploring families' experiences, but I believe that this approach would have detracted from the value of critical narrative analysis (CNA). The advantages of CNA have been threefold: 1) The sense of journey it has allowed me to perceive in families' experiences, allowing them to define who they have been and who they are now (Murray, 2003). 2) Narratives have depicted a shared journey involving many different parties, as "a shared version of reality" (Hiles & Cermák, 2008). From the perspective of CNA I was able to consider the significance of families' OD experiences within the interpersonal context of their lives, both recently and over time. 3) By considering their how a narrative may be told in response to another narrative, and by considering how narratives appear to relate to critical social theory, CNA has enabled me to consider the function of narratives in families' lives. This last point was important because of the particular relevance of canonical narratives of mental healthcare to this sample. By using IPA, I would not have analysed participant experience through this critical narrative lens. Although IPA might have enabled me to identify shared experiences within families, in clustering themes I would not have done this chronologically with respect to the master narrative, as I did with CNA, and, therefore, the journey aspect of families' experiences would have been lost. IPA may not have included a focus on identity formation, which was a useful lens for identifying the service-user's journey. Although IPA might provide an interesting insight into what it is like having OD as a family, I believe it would have provided a narrower perspective of this than CNA. I think that the broader approach of CNA was more suited to my broader exploratory aims. Furthermore, if recovery is a personalised journey of discovery (Repper & Perkins, 2012), then it could be argued that the journey

perspective, afforded to me by narrative analysis, has helped me to identify manifestations of this in families' portrayed experiences.

### Suggestions for Future Research

The individual and systemic differences within and between families, particularly differences in mental illness, developmental disorder and interpersonal family dynamics, as represented by my sample, suggest a need for research into how these differences may be measured and how the effectiveness of OD may relate to these differences. The imminent OD randomised-control trial (Pilling, 2016), may be interested to consider incorporating quantitative measures of these differences, to allow analysis of their relationship to outcome measures. It might also be interested in using qualitative measures to explore how these differences are experienced by users in relation to OD.

Researchers may be interested in identifying what exactly causes user anxiety in OD, how it affects users, and how acceptable it is to them. Such research might help determine whether more needs to be done to support OD users, to enable them to tolerate the uncertainty of OD. Given the focus in this study on how people can affect each other through relationships, what also seems worthy of further investigation is whether anxiety is related to professionals being unclear about their roles in OD. Holmesland, Seikkula, Nilsen, Hopfenbeck and Arnkil (2010) have shown that professionals can feel uncertain about their roles in OD. Both quantitative and qualitative methods could be used to identify and explore the experience of users' and professionals' anxiety in OD.

What seems particularly pertinent to explore further is to what extent OD is able to facilitate supportive relationships in social networks beyond OD and mental health services, so that the effect of OD can be sustainable. It seems important to explore the factors and processes within the therapeutic relationships fostered in OD that lead to social inclusion and recovery further. Both quantitative methods, to identify the correlational and causative factors that may relate to the development of supportive relationships, and qualitative methods to further explore how these relationships are experienced by individuals and families, could be useful. The value of these relationships

and the process of their formation may be conceptualised, and thereby measured by using the humanistic and compassion perspectives used in this research. From their review of the literature available on the use of peer-support workers (PSWs) in mental healthcare, Repper and Carter (2011) conclude that PSWs appear to be more able to “promote hope and belief in the possibility of recovery” than mental health professionals. Indeed, service-users’ improved engagement with supportive social networks has been shown to be related to the involvement of PSWs (Ochocka, Nelson, Janzen, Trainor, 2006; Forchuk, Martin, Chan, & Jensen, 2005). It is necessary, however, to acknowledge that there is little evidence about the effective characteristics of PSWs (Shepherd & Repper, 2016). Given that NHS OD is being developed to include PSWs, it could, therefore, be that research into PSWs ability to promote social inclusion and recovery would be particularly valuable.

By interviewing families together, I have collected co-constructed narratives within which individuals’ experiences are interwoven. Individuals may, however, have felt pressured not to dissent from the dominant narrative in order to avoid upsetting their relatives, as Kitzynger (1994) suggests is possible in group interviews. It may be possible to study families’ experiences of OD by using a qualitative approach and individual interviews, with multiple members of the same family. This may lead to different narratives emerging. Each family could then be invited to participate in a group interview of their own, using the same interview schedule, but with the aim this time of collecting a co-constructed narrative. This research design may then enable a researcher to analyse how individual and group interviews differed in their narrative constructions, which may reveal a broader range of experience than just co-constructed narratives alone. However, arguably, the order in which interviews are done could affect the way in which narratives are constructed. This approach may also be labour intensive for a researcher and, therefore, the number of families he, or she, might be able to investigate in this way could be particularly limited.

In the spirit of empowering SUs via a network-orientated and dialogic approach, Beresford (2015) advocates for service-users and researchers collaborating to understand what ‘being mad’ means. Beresford, Nettle and Perring (2009) emphasise that service-users do not want alternative dominating sets of ideas produced by

research to be again imposed upon them. Indeed OD users may be best placed to consider which research questions are worth asking, as well as which treatment processes and outcomes matter (Faulkner & Thomas, 2002). Researchers may wish to work alongside OD users to help them to design research into their experiences of OD as a family. They may prefer to have more control over when, and by whom, they are interviewed. Perhaps an ethnographic user-led approach could be used. The OD users could become the interviewers of each other, audio recording themselves discussing their experiences of, and since, OD in their own homes without a professional researcher. Perhaps, if these audio recordings were scheduled to happen at various points in families' OD journeys, they could provide a closer representation of their experiences of OD as a family. This may offer an efficient way of gathering large amounts of qualitative data over a long period of time, which is more organically produced from within the family than is possible from a professional researcher-led interview. The latter, of necessity, involves a co-constructed narrative between interviewer and interviewee to some extent.

## **Conclusion**

This research contributes to the current gap in the literature on the experience of families' who have been using OD in the NHS. It identifies how the systemic use of humanistic and compassionate therapeutic relationships, not only within OD meetings but subsequently beyond them, appears to support families with a broad range of needs along their journeys of recovery. It identifies important issues, however, about how OD may be challenging for some individuals and families, and about how sustainable the support of OD is. Bakhtin (1975) said "for the word (and consequently for a human being) there is nothing more terrible than a lack of response". If this theory, upon which OD is founded, is true then the response to families' voices promulgated by this research must be appropriate.

Both as someone with an enduring mental health condition, a service-user and as a clinical psychologist, Perkins (2015) states that what she and other service-users need are "[h]ope inspiring relationships and environments where we can explore our own reality (rather than have it defined for us by the experts) and take control over our lives and destinies." Indeed this need is implied within the narratives of OD experience

explored in this research. What seems crucial is that research and the clinical development of OD continues to identify how such relationships and environments are best facilitated, with respect to the user's experience and voice, so that they may continue to be empowered to define what is best for them. I hope that this research will act to amplify the voices of the families interviewed, so that they can be more clearly heard in the ongoing dialogue about the value of OD and recovery in NHS mental healthcare.

### **Final Reflexive Statement**

The journey as a researcher to this point has been relentlessly challenging, from the outset of writing an initial research proposal up to and including the process of writing this thesis. I have noticed that the nature of these challenges have varied, for example from managing the uncertainty of participant recruitment to the more cognitive task of writing. At each stage, I am very grateful to have been supported by my research supervisor, who has continuously helped me to think about this research, but, ultimately, I have had to make decisions about its direction by myself, as is the nature of doctoral work. The learning curve has been steep and ever ascending. With continuous reflection on my research choices, however, I have learnt how I could best achieve my research aims and, as a consequence, I believe I have developed as a researcher. I have also developed as a clinical practitioner I believe, as my clinical values with respect to mental healthcare have been influenced by the research.

One of the main difficulties I can see in hindsight was deciding what it was exactly that I wanted to research. I had initially been interested in the experiences of families, who had been caring for a relative who had been supported by an early intervention in psychosis team. When it became possible for me to research OD, I had assumed that this would give me an opportunity to explore the experience of families who had a relative with psychosis and had been using OD. Due to the early trial status of OD and the fact that it was being used in community mental health teams rather than early intervention in psychosis teams, the sample available actually included a broad range of SMI presentations. The particular interests I had in psychosis were no longer so relevant, so I reconsidered my interests and thought about how they might suit research with this

sample. Upon realising that I had several broad interests in this regard, I recognised that I needed to specify my interests in order to develop an interview schedule. Given that my interests in mental illness and mental healthcare were so numerous at that time, this was challenging. By reflecting upon, and confirming my interests, I identified the scope of my research. These identified interests gave me a focus, which ultimately helped me to decide upon a suitable method of analysis. By understanding my own point-of-view and bringing myself back to this, I was able to identify the direction my research should take. This strengthened my understanding of the importance of identifying one's subjectivity as a researcher in qualitative research.

Personal reflection had helped me to identify my beliefs about NHS mental healthcare, but stage one of CNA had helped me to recognise my assumptions more clearly. It was very interesting to witness how my own critical viewpoint about disempowering mental healthcare could, in itself be disempowering. This has helped me to see just how powerful critical social viewpoints can be in terms of the judgements they can imply, and how, ironically, these judgements can be obscured by an opinion about social justice. As a researcher I have learnt to be more cautious and questioning about my perspectives. This critical reflection has I believe helped me to identify a broader range of experiences, as portrayed within families' narratives. As a clinician, this experience reminds me of the power of the psychological models I use in my practice, and hence the imperative to be critically self-aware of the assumptions about people that may be implicit in my practice, in order to be more broadly open to their experience.

The findings of this research have helped me to see that, although OD was fairly empowering for the service-users and families I interviewed, what is potentially more empowering than recognising this alone is to also appreciate the potential limitations of the approach, as well as the constrictions of the wider social context in which it functions and upon which it relies. As both a researcher and a clinician, I have come to be more fully aware of the need to attempt to understand people in respect of their social context, but also with respect to the social injustice which may exist in their lives. By being more appreciative in these ways, I hope that my future work will help contribute towards more sustainable recovery journeys for individuals, families and, even, wider communities.

Having been moved by families' evocative narratives, I have come to appreciate more fully how powerful mental health systems can be in influencing the experiences of their users. It seems that, by placing the therapeutic relationship at the centre of the mental health system, its users have more say over their experience. It is, perhaps, the powerful experience of having one's voice carefully responded to, that we can all appreciate. Although responding kindly and carefully to another may seem like a simple act, perhaps an act that we might take for granted, this research has helped me to appreciate the complex implications of both its absence and its presence.



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## Appendix

### Appendix 1: Participant Information Leaflet (with any information that might increase the chance of a participant being identified removed or changed)

<p><b>Who are we looking for?</b></p> <ul style="list-style-type: none"> <li>- Either you or your relative has recently experienced a mental health difficulty.</li> <li>- You and your family have participated in Open Dialogue meetings.</li> <li>- The person in your family who has recently experienced the mental health issue has been judged to be well enough to participate in this study.</li> </ul>	<ul style="list-style-type: none"> <li>• You will have the opportunity to develop your understanding of your relatives' experiences.</li> <li>• By developing the understanding of what it is like to be an Open Dialogue service user you may help develop this service model, thereby helping others in similar situations as your own.</li> </ul>	<p><b>Participant Information</b></p> <p><b>What is the experience of open dialogue service users?</b></p>
<p><b>Who will be unable to take part?</b></p> <p>For ethical reasons we cannot accept people who are unable to engage in the process of being interviewed about their Open Dialogue experience due to:</p> <ul style="list-style-type: none"> <li>- Being acutely unwell (as well as your judgement, this will be judged by your Care Co-ordinator).</li> <li>- Their English language ability being too limited.</li> </ul>	<p><b>Interested in participating? Want to know more?</b></p> <p><i>Would it be ok if I called you to discuss this further?</i>  <b>If this is ok please tell one of your Open Dialogue professionals.</b></p> <p>If you prefer you can email me: [REDACTED]</p> <p>Should you have any questions for the research supervisor, Dr. Aylish O'Driscoll, she can be emailed: [REDACTED]</p>	
<p><b>What are the advantages of taking-part?</b></p> <ul style="list-style-type: none"> <li>• You will have the opportunity to think about and possibly learn from your Open Dialogue experience.</li> </ul>	<p><b>Please note:</b> If decide to participate but change your mind at a later date, there is no obligation for you to continue to participate. Your NHS care will be unaffected.</p>	<p><b>Research Team</b></p> <p><b>Jack Closs</b> – Trainee Counselling Psychologist, Lead Researcher</p> <p><b>Dr. Aylish O'Driscoll</b> – Counselling Psychologist, Research Supervisor</p>





### Background

As you may be aware, a London NHS Trust is trialling a new service model approach to offering support to people in mental distress and their families. You may be aware that this approach is based on a model called Open Dialogue.

### Aim

The researcher is undertaking this study as part of his professional doctorate training in counselling psychology at City University.

This study aims to describe the experience of people who have used the open dialogue approach. It is also interested in how useful this service model has been.

### Outline of project

This project will be exploring meaningful patterns of experience of being an Open Dialogue service-user as each family discusses this together with the lead researcher. Themes of experience will be looked for across a data set of such family interviews.

This project has been ethically approved by City University London

Research Ethics Committee and South East Coast-Surrey Research Ethics Committee.

### What is asked of people who are interested in participating in this study?

***What will you be asked to do?*** You would be asked to participate in a group interview with your family who you have had Open Dialogue meetings with. The interview would either be at Havering Recovery Team offices or if you prefer your home, at your earliest convenience. It would last up to 1.5 hours.


Your family will then be offered up to an hour to discuss how the interview was with the researcher. If you have been experiencing mental health issues then you will be offered an hour with the researcher to discuss the interview individually. These meetings are optional and can be arranged at time that's most suitable for you.

***How long will you be involved?*** For the length of the interview and any support you choose to have after. The researcher hopes to interview participants at their earliest convenience.

***How long will the research study last?*** It is hoped that the research will be completed by December 2016.

***What will happen if I agree for the researcher to contact me about participating?*** The researcher will first answer any questions you may have about the research. If you would like, the researcher will arrange a time with you and your family to discuss participating in the study in person, or he could send you more detailed information for you and your relatives to consider. If you would like to meet before the interview then this would either be at community mental health team offices or if you prefer your home, at your earliest convenience. If you are then willing to participate in the study you and your family will be asked to sign a consent to participate form, either at the time of the interview or if you have chosen to meet beforehand, then.

***What research method is being used?*** The researcher will use a qualitative method that aims to explore the meaning of you and your family's experience of being an Open Dialogue service user.



CITY UNIVERSITY  
LONDON

## WHAT HAS YOUR EXPERIENCE OF OPEN-DIALOGUE BEEN LIKE?

As part of my (lead researcher, Jack Closs) doctorate training in counselling psychology I am looking for volunteers to take part in a study on the experience of Open Dialogue service-users.

***What will you be asked to do?***

You would be asked to participate in a group interview with the relative/s who you have had Open Dialogue meetings with. The interview would either be at community mental health team offices or if you prefer your home, at your earliest convenience. It would last up to 1.5 hours.

***Would it be ok if I called you to discuss this further?***  
**If this is ok please tell one of your Open Dialogue professionals.**

If you prefer you can email me: [REDACTED]

***What are the benefits of taking part?***

- You will have the opportunity to think about and possibly learn from your Open Dialogue experience.
- You will have the opportunity to develop your understanding of your relatives' experiences.
- By developing the understanding of what it is like to be an Open Dialogue service-user you may help develop this service model, thereby helping others in similar situations as your own.

***How will you be supported in this process?***

Your family will then be offered the option of up to an hour with the researcher to discuss how the interview was. If you have been experiencing mental health issues then you will be offered an additional hour with the researcher to discuss the interview individually.

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London. Ethics approval number: [PSYCH\(P/F\) 14/15 127](#). If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [REDACTED] or via email: [REDACTED]

Appendix 3: Participant Information Sheet (with any information that might increase the chance of a participant being identified removed or changed)



**Title of study:**

**What is the experience of families who are using Open Dialogue in the NHS?**

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

The researcher is undertaking this study as part of his professional doctorate in counselling psychology at City University.

This study aims to understand the experience of people who have used the Open Dialogue approach.

**Why have I been invited?**

You have been chosen to participate in this study because:

- The researcher believes that you may be interested in participating in the study.
- Either you or your relative is an NHS community mental health service-user.
- You and your family have participated in the Open Dialogue service.
- Your community mental health team and the researcher consider that you would be suitable for the study.

We cannot accept participants who cannot speak fluent English because the researcher only speaks English.

**Do I have to take part?**

No, participation in the project is voluntary. If you do decide to take part you will be asked to sign a consent form. You would still then be free to withdraw from the study. Your NHS treatment will not be affected by any such decision.

You may withdraw from the study at any stage. This means you can withdraw your consent to participate in an interview, or if you have already been interviewed you can have your data withdrawn from the study or any unpublished papers written on it. The researcher aims to publish the results between September 2016 and December 2016 so if you wish to withdraw you must please do so by September 2016. If you withdraw from the study all data that you have given will be immediately deleted.



If you wish to withdraw from the study please inform the researcher. The researcher will ask you if you wish to discuss your reason/s for this decision with him, his supervisor or your mental health care team, though you are not required to do so.

### **What will happen if I take part?**

*What exactly will happen?* You will be asked to complete a consent to participate form. You will be asked by the researcher to arrange a time that you and your family can meet to be interviewed about your experience of being an Open Dialogue service-user. The researcher will have several open-ended questions that might help you and your family to discuss your experience. After the interview you will have the option of some time with the researcher to reflect on how the interview experience has been.

*What research method is being used?* The researcher will use a qualitative method that aims to explore the meaning of you and your family's experience of being an Open Dialogue service-user. Your family will be interviewed together in a group.

*Where is the research taking place?* Wherever is most convenient for you and your family, this may be the community mental health team offices, which you may be familiar with, or your home.

*What do I have to do?* Once you have clarified any queries you may have and signed the consent to participate forms, you and your family will meet with the researcher once for up to 1.5 hours to discuss your experience of being an Open Dialogue service-user. Your family will then be offered up to an hour to discuss how the interview was with the researcher. If you have been experiencing mental health issues then you will be offered an hour with the researcher to discuss the interview individually.

### **What are the possible disadvantages and risks of taking part?**

Since the subject matter of this research is of a highly sensitive nature it is likely that uncomfortable feelings may be raised by the interviews. This is why the researcher is offering the debriefing sessions after the interview as described above. Should there be any subsequent concerns the researcher may wish to inform your community mental health team, so that further support may be considered. He will try to discuss this with you first however.

### **What are the possible benefits of taking part?**

- You will have the opportunity to develop your understanding of your Open Dialogue experience.
- You will have the opportunity to develop your understanding of your relatives' experiences.
- By developing the understanding of what it is like to be an Open Dialogue service-user you may help develop this service, thereby helping others in similar situations as your own.

### **What will happen when the research study stops?**

- The results of the study will be published in City University Library.

- Should you have consented to being contacted with a copy of the results, you will be.
- Your data will be kept for up to 5 years in order to publish the results in a peer-reviewed journal and to inform mental health professionals about these results.

#### **Will my taking part in the study be kept confidential?**

- Your data will be stored on a password-protected computer and in locked filing cabinets. These filing cabinets will be based at City University.
- Your data will be anonymized by you being allocated a pseudonym by the researcher. The researcher will henceforth only identify you by this pseudonym. The researcher will store the code that identifies your true identity on a password-protected computer in case you need to be identified for the safety reasons outlined above. Your anonymity will otherwise be maintained at all times.
- The researcher may need to discuss the data that you provide with his research supervisor. You will not be identifiable to the research supervisor because the researcher will only refer to you by pseudonym. The research supervisor will store any information about these meetings that is necessary on a password-protected computer that only she will have access to. She will not disclose this information to anyone else.
- Should you communicate any risk towards yourself or others however, or from others e.g. sub-standard professional practice, this may need to be discussed with your community mental health team. The researcher will aim to discuss any such disclosure with you first however.
- If you wish to be contacted about the results of the research then your contact details will be kept confidentially for 18 months after your interview, otherwise they will be deleted immediately.
- Audio recordings will be transferred from the Dictaphone onto the researcher's password-protected computer and backed up (copied) onto the researcher's password-protected external hard-drive, they will then be deleted from the Dictaphone. The researcher aims to complete all transcriptions by March 2016. Immediately after each transcription is complete its respective audio recording will be deleted from the researcher's computer.
- As soon as the data is no longer being used for the purposes above, or 5 years has passed, your data will be deleted.

#### **What will happen to the results of the research study?**

All participants will continue to be anonymous throughout the following processes and in any publications or dissemination.

The interviewer will ask you before the interview if you would like to be sent a copy of the published results. If you request either of these it will be posted to you within 18 months of your interview.

The results of the study will be written into a thesis document which will be assessed by two independent assessors. The researcher will then be invited to meet with a panel of 3 assessors to discuss his standpoint in relation to the study and its results. If the study is then judged to be suitable it will be published by

City University and will be available to City University staff and students upon request from City University Library, London.

It is hoped that a paper will be published about the study and its results in a mental health journal, accessible to the general public.

It may be that there will be an opportunity for further public dissemination, such as discussing the results of the study with NHS employees, Open Dialogue professionals, or at conferences.

### **What if there is a problem?**

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *What is the experience of families who are using Open Dialogue in the NHS?*

You could also write to the Secretary at:

Anna Ramberg  
Secretary to Senate Research Ethics Committee  
Research Office, E214  
City University London  
Northampton Square  
London  
EC1V 0HB  
Email: [REDACTED]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

### **Who has reviewed the study?**

This study has been approved by City University London Research Ethics Committee, [approval code: PSYCH(P/F) 14/15 127].

This study has been reviewed and received favorable opinion by South East Coast-Surrey Research Ethics Committee.

### **Further information and contact details**

If you have any further questions, or think you may want to participate please inform one of your Open Dialogue team or email the researcher, Jack Closs:

[REDACTED]

Alternatively, you may wish to contact the research supervisor, Dr. Aylish O'Driscoll: [REDACTED]

**Thank you for taking the time to read this information sheet.**

#### Appendix 4: Participant Consent to Participate Form



Title of Study: **What is the experience of families who have used Open Dialogue in the NHS?**

Ethics approval number: *PSYCH(P/F) 14/15 127*

Please initial box

1.	<p>I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve:</p> <ul style="list-style-type: none"><li>• being interviewed by the researcher</li><li>• allowing the interview to be audiotaped</li></ul>	
2.	<p>This information will be held and processed for the following purpose(s):</p> <ul style="list-style-type: none"><li>• To analyse your experience of being an Open Dialogue service-user.</li></ul> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party, except for a professional transcriber. The professional transcriber will sign an agreement to keep all interview data confidential. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.</p>	
3.	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.</p>	
4.	<p>I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.</p>	
5.	<p>I agree to take part in the above study.</p>	

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

When completed, 1 copy for participant; 1 copy for researcher file.

## Appendix 5: Pilot Group Interview Schedule

### Pilot Interview Schedule

Interviewing 3 classmates about their experience of counselling psychology training.

#### **Introducing the interview schedule to participants:**

The interview will last up to an hour.

If it is ok with you I will record the interview to help me learn from the process. This information will not be shared with anyone and will be deleted within the next few weeks.

I will ask you some questions about your experience of counselling psychology training. I will ask them to the group and whoever wishes to answer may do so, though I encourage you all to give a response at some point. This may be a direct response to the question or to somebody else's response to the question. I may at times seek viewpoints from individuals after somebody has answered or a discussion has taken place. This will be to encourage individuals to express *their* experience of what the questions refer to. It may also be to ask you to consider your experience in relation to another member of this group's experience.

Probing questions will only be used to clarify meaning and to help participants elaborate their perspectives. Examples may include:

- "What was the experience like for you?"
  - "Have I understood this correctly....?"
  - "Can you explain what you mean by....?"
  - "Can you tell me more about that?"
  - "Do you agree with what *\*classmate's name* has said about this?"
  - "Is there anything you want to add to what your classmate has said about this?"
  - "Does what *\*classmate's name* has said about this change your account of.....?"
- What was your experience of counselling psychology training?
    - Did your experience of counselling psychology training remain the same or change? What was your subsequent experience of counselling psychology training like?
    - Can you describe what your experience of being listened to on your counselling psychology training days was like?
    - Can you describe what your experience of expressing yourself on the course training days was like?
    - How would you describe your training cohort's experience of counselling psychology training?
  - Since your counselling psychology training began, what has your experience of your training cohort relationships been like?

- Since your counselling psychology training started, can you tell me what your experience of being listened to by your training cohort has been?
- Since your counselling psychology training began, can you tell me what your experience of expressing yourself to your training cohort has been?
- What is your understanding of the situation that led you to decide to train in counselling psychology?
  - Since you began counselling psychology training has your understanding of the situation that led you to decide to train as a counselling psychologist changed? If so, how?
- Please describe any significant moments since you began training, which have struck you as particularly important in *shaping* your current professional identity.

*Ask for elaboration on the times they have described, to what extent each was related to change or not?*

- Please describe any significant moments since you began training, which you have found or thought were a *challenge* to your development of your professional identity.

*Ask for elaboration on the times they have described, to what extent each was related to change or not?*

- How did it feel to be training in counselling psychology without your placements being arranged for you by the course organisers?
- What was it like having the same tutor group in years 1 and 2?
- Have I missed anything about your experience since you started counselling psychology training?

## Appendix 6: Interview Schedule

### Interview Schedule

Probing questions will only be used to clarify meaning and to help participants elaborate their perspectives. Examples may include:

- “Can you explain what you mean by....?”
  - “Have I understood this correctly....?”
  - “Can you tell me more about that?”
  - “What was the experience like for you?”
  - “Do you agree with what *\*relative’s name* has said about this?”
  - “Is there anything you want to add to what your relative has said about this?”
  - “Does what *\*relative’s name* has said about this change your account of.....?”
  - “What is it like talking about this now?”
- What was your experience of Open Dialogue meetings?
    - Did your experience of Open Dialogue meetings remain the same or change? What was your subsequent experience of Open Dialogue meetings like?
    - Can you describe what your experience of being listened to in the Open Dialogue meetings was like?
    - Can you describe what your experience of expressing yourself in the meetings was like?
    - What was it like being in the meetings with your family?
  - Since the Open Dialogue meetings began, what has your experience of your family relationships been like?
    - Since the Open Dialogue meetings started can you tell me what your experience of being listened to by your family has been?
    - Since the Open Dialogue meetings began, can you tell me what your experience of expressing yourself to your family has been?
  - What is your understanding of the mental health problem that has led you to seek support?
    - Since attending Open Dialogue meetings has your understanding of this problem changed? If so, how?
    - Please describe any significant moments since you began attending Open Dialogue meetings, which have struck you as particularly significant in changing your understanding of the problem.

*Each participant will then be asked to elaborate on the times they have described, elaborating to what extent each was related to change or not.*

- What was your experience of the team of mental health professionals you worked with?
  - Since you began Open Dialogue meetings, did your experience of this team remain the same or change? If it changed, how did it change?
- Is there anything that could have been more helpful in your Open Dialogue experience?
- Have I missed anything about your experience since you started attending Open Dialogue meetings?
- **REMIND THEM ABOUT DEBRIEFING SESSIONS**
  - “HOW HAS THE INTERVIEW BEEN?”
  - “DO YOU FEEL OKAY ABOUT WHAT WE’VE JUST DISCUSSED?”
  - “WOULD YOU LIKE TO DISCUSS ANYTHING?”
  - “WOULD YOU LIKE ANOTHER MEETING TO DISCUSS HOW THE INTERVIEW HAS BEEN?”



## Appendix 7: Questions Asked From Interview Schedule in Each Interview

### **Family 1**

- What was your experience of OD?
- Did your experience of Open Dialogue meetings remain the same or did change over time?
- Can you describe what your experiences of being listened to in the Open Dialogue meetings was like?
- What was it like being in the meetings with your family?
- Since Open Dialogue meetings began, what has your experience of your family relationships been like?
- What's your understanding of the Mental Health problem that has led you to seek this support?
- Would you describe any particular significant moments of change in that understanding that you can think of in your meetings?
- What was your experience of the team of Mental Health professionals you worked with?
- Did your relationships with professionals change over time since you began OD?

### **Family 2**

- What was your experience of OD meetings?
- Have I missed anything about your experience that you haven't told me?

### **Family 3**

- What has been your experience of OD?
- Has your understanding about your mental illness changed since you began OD?
- What have your relationships with your family been like since OD?
- Is there anything that I've missed about your OD experience?

### **Family 4**

- What was your experience of OD?
- What have your family relationships been like since OD?
- Did your relationships with professionals remain the same or change since you began OD?

- Is there anything that could have been more helpful in your OD experience?
- Have I missed anything about your OD experience?

#### **Family 5**

- What has been your experience of OD?
- What was your experience of being listened to in OD meetings?
- What was it like being in OD meetings with family members?
- What have your experiences of family relationships been like since starting OD?
- What is your understanding the mental health problem that let you to see support? Has your understanding about your mental health issue changed since you started OD?
- What have your relationships with OD professionals been like since commencing OD?
- Is there anything that could have been more helpful in your OD experience?
- Have I missed anything about your OD experience?



**CITY UNIVERSITY  
LONDON**

***What is the experience of families who have used Open Dialogue in the NHS?***

**DEBRIEF INFORMATION**

Thank you for taking part in this study. Now that it's finished we'd like to explain the rationale behind the work.

**Research Background**

You may already be aware of the background to this research, but I outline it anyhow for those who may not be fully aware.

Open Dialogue

The Finnish Open Dialogue approach believes that meetings of mental health professionals, people experiencing episodes of psychosis and their families should focus on facilitating dialogue that tolerates uncertainty and encourages a non-hierarchical discussion, in which a mutually meaningful and a need adapted care plan is hoped for (Seikkula, 2002).

The effectiveness of this approach (Seikkula et al., 2006) has not been subjected to the most rigorous testing (Ross, 2013). The relevance of the research is criticised as it mostly focuses on psychosis only. Its effectiveness in places other than Finland is questioned because of the little amount of research that has looked into this (Thomas, 2011).

Open Dialogue in the NHS

A London NHS trust is working with other NHS trusts to implement a rigorous trial of Open Dialogue for severe mental illness (SMI) (likely to have had psychiatric hospital admission/s, or more than 6 months of community psychiatric care, with more than 1 worker).

**The Test-Phase Open Dialogue Service Model Approach**

NHS service-users who have consented to work with the Open Dialogue approach will be people who are suffering from SMI, being cared for by an NHS community mental health team, or a relative of such a person.

Open Dialogue practitioners in this test phase will be mental health professionals who are being trained in Open Dialogue.

All Open Dialogue 'network meetings' will be based on Open Dialogue principles. Treatment as usual will be continued but network meetings will be central to the care process.

An initial meeting with the person suffering from SMI, their family (if they are available) and Open Dialogue practitioner/s, will be arranged at either the service-users' home or NHS premises. The treatment plan will be reviewed in this meeting. The same Open Dialogue practitioner/s will meet with the person experiencing SMI and their family (depending on their availability) for subsequent review sessions. These meetings will continue until the service-users and Open Dialogue practitioners agree that they are no longer necessary.

### **Study Rationale and Aims**

This study's primary aim is to explore how this Open Dialogue service model approach is experienced by Open Dialogue service-users.

It wants to help researchers and mental health professionals to think about Open Dialogue service-user experience, so that understanding and evaluation of this mental healthcare approach can be further developed.

It also hopes to enable Open Dialogue service-users to learn more about their experience by talking about it. It is hoped that service-users will also learn more about their experience by reading the research findings, reflecting on them and comparing other service-users' experiences to their own. These secondary aims are hoped for consequences of what the study reveals about Open Dialogue service-users' experience.

Since Open Dialogue aims to help its service-users develop their understanding of SMI through dialogue and the researcher's interest in how families adapt to SMI, service-user experience of Open Dialogue as it is constructed through discussion within the family is the focus of this study.

### **Research approach and aims:**

This study is interested in how your experience of being an Open Dialogue service-user is constructed in your family, this is to say how your experience is understood by yourselves as you talk about it together, and how the social context affects the meaning of your experience.

The researcher will be looking for meaningful patterns of experience across your family and across the whole data set - across around 5 other families. He will also be thinking about how you have used stories to describe your experience.

There has not yet been any research into the experiences of Open Dialogue service-users in the UK. This study aims to develop understanding about this.

The researcher does not yet know what understanding of service-user experience to expect.

### **What will happen next?**

The researcher aims to collect data from participants between January 2016 and August 2016. The researcher aims to then publish the results of the study in City University Library between January 2017 and June 2017. Those participants who have consented to being contacted about the results will then be contacted. Once they have been, their contact data will be deleted. The anonymised results will then be written up in order to hopefully publish them in a peer-reviewed journal. The researcher aims to publish this paper within 5 years of collecting all the data,

so by December 2020. Once this paper has been published or after 5 years, whichever is sooner, all participant data will then be deleted.

If you withdraw from the study your data will be immediately deleted.

Audio recordings will be transferred from the Dictaphone onto the researcher's password-protected computer and backed up (copied) onto the researcher's password-protected external hard-drive, they will then be deleted from the Dictaphone. The researcher aims to complete all transcriptions by August 2016. Immediately after each transcription is complete its respective audio recording will be deleted from the researcher's computer and external hard-drive.

**We hope you found the study interesting. If you have any other questions or concerns please do not hesitate to contact us at the following:**

- Please call the researcher, Jack Closs on [REDACTED] or email: [REDACTED]
- Alternatively, you may wish to contact the research supervisor, Dr. Aylish O'Driscoll: [REDACTED]

Ethics approval code: *PSYCH(P/F) 14/15 127*



## **Transcriber Confidentiality Agreement**

Title of Study: **What is the experience of families who have used Open Dialogue in the NHS?**

Ethics approval number: *PSYCH(P/F) 14/15 127*

Please initial box

1.	The audio information I will be given will be used for the following purpose only: <ul style="list-style-type: none"><li>• To transcribe</li></ul> I understand that any information I hear and transcribe is confidential, and that I cannot disclose any of this information to anyone other than the researcher.	
2.	All audio data will be deleted by the transcriber after it has been used for the purpose above. All copies of transcriptions will be deleted by the transcriber after a copy has been given to the researcher. All transcriptions and audio recordings will be stored on a password protect computer.	
3.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

When completed, 1 copy for transcriber; 1 copy for researcher file.

## Appendix 10: An Example of Stage 4 Analysis

### **Key**

L = Laura

V = Vivienne

J = Jerry

SU = Service-user

TAU = Treatment-as-usual

MH = Mental health

Grey headings = Sub-themes

### **Allowing Space for Laura's Voice and Learning More About Her Mental Health**

#### The value of talking

L: Sceptical at first that talking would help

V: Family sceptical at first and did not know anything about OD. It was suggested that because L was less manic she would be suitable for OD.

V + J: Hard to understand what OD is before trying it.

L: Quickly saw how talking was helping her and helping her to communicate her feelings to family and professionals.

V & J: It took one session for them to feel confidence in the OD process; this was exciting.

All: L was well enough to be aware of her mental health difficulties and her family was willing to talk about them with her when they started OD.

#### Feeling heard and understood

L: By expressing how she felt when unwell, she helped her parents to make sense of her behaviours at this time.

L: Gave SU a voice.

J: SU is given permission to speak. Her concerns about worrying family have prevented her from speaking in the past.

L: Because feelings and individual experiences are valued as something that can be respected and learnt from, L feels less need to hide her feelings.

J: An opportunity for everyone to discuss difficult situations in the past and learn from them, rather than hold back from doing so.

V: Rather than being scared to discuss L's difficulties with her, it was different with Open Dialogue, which absolutely helped her more than anything.

J: OD validated L's judgement on her own mental health.

J & V: OD helped them speak about their past negative experiences of mental healthcare and be heard and responded to by the system.

V & J: Manic behaviour understood in OD.

L: Feeling listened to in OD in contrast to TAU, which angered her.

J: Discussing frustrations of prior care helps find relief and understanding about what happened during distressing prior events.

V & L: Connection with professionals via conversation, in contrast to TAU, where angry and leave.

### **A Free-Flowing and Supportive Conversation, in Which Multiple Viewpoints are Encouraged**

L: OD is done in a relaxing environment, in which you can do what you want.

L, V & J: OD dynamic changes: cosy, not us vs. them.

V & L: Because they're not taking notes you don't feel under the spotlight.

L & V: Supportive, non-judgemental environment in OD.

V: Non-judgmental environment without agenda allows conversation to flow.

V & L: Using humour in meetings to explore experience.

J: Free-flow = relaxed atmosphere.

All: Free-flow, according to need of SU.

Having the time to talk freely means that the SU can be less defensive, and more expressive of how she feels. This can then lead onto practical solutions, flexibly tailoring the care-plan accordingly.

J & V: Having the time to talk freely means that the SU can be more expressive of how she feels, allowing professionals to monitor her mental health. This can then lead onto practical solutions, flexibly tailoring the care-plan accordingly.

V: OD is flexible, however much you need.

J & V: Flexibility of support is comforting for them because otherwise they worry about L's vulnerability.

L: OD an opportunity to process issues with TAU, without reproach.



All: long-term, no pressure for immediate results, sometimes lots comes out, sometimes little.

V: TAU = agitating; OD = calming, when talked about.

J: Conversation flows in OD without concentration on any one aspect necessarily.

Things that are still a concern are naturally returned to.

J: a very personal relationship.

V: More like friends than professional-client relationship.

V: Like friends, very personal.

V: OD has helped her and J a lot too, enlightening.

V: Therapy for relatives too.

### Widening perspectives (Explore together, multiple perspectives)

J: Reflecting team is strange.

L: Reflecting team shows that professionals are really listening to everyone.

L: Reflecting team helps SU to think about things from another perspective.

J: Reflecting team shows that they are listening. In contrast to TAU: you get filed away.

L: Everyone on the same page, a shared understanding of the situation.

V: Family learnt much more about bipolar disorder, by listening to SU describe it. They were surprised by how much more they learnt.

J: Dealing with difficulties together, not feeling alone with them, as in CBT. Off-loading and, then, being thought about (in reflection), without the pressure to load it all back on again.

J: OD allows for open-ended discussion and multiple perspectives, often varying seemingly according to who's in the meeting. You aren't constrained by a short time or professionals' agenda.

V: Different family perspectives help different relatives think about the most helpful relationship they can have with SU.

All: Emma learnt more in OD what L's manic behaviour is like and was able to accept her parents' perspectives on how to best support L.

L: Family there helps her remember details that proved valuable to explore, something you would not necessarily remember in individual therapy.

V: Collectively, recounting episodes that L deems important enough to discuss helps with revealing and remembering important aspects of the SU's experience, e.g. not being listened to when trying to get help.

J: Hopefully, insights gained into L's behaviour can be passed on to other professionals, if they need to understand it in the future.

L & J: Because more is being talked about and remembered, the ups and downs of these memories (sadness and humour) are experienced. Going through it together helps.

L: Reduced anxiety with personalized planning, tailored to her needs via reflections of professionals in OD.

All: Communal decision-making. Respects SU's self-understanding and self-care opinion, empowers SU.

J: Communal decision-making results in relatives being less concerned about care-plan changes.

V + J: OD provides ongoing shared monitoring, taking pressure off relatives to notice blips.

All: Problems can be identified early and dealt with there and then.

J & V: Relatives confident that SU won't need another hospital admission due to OD's continual monitoring.

V & J: L's ability to engage with OD will be there permanently now, but OD support is provisional.

L: OD was a place she could express her emotions about being hospitalized, rather than hold onto resentment towards the MH system. Subsequently, it enabled her to have more self-understanding about her illness and how she needs to look after herself – resilience.

All: OD models how families should respect SMI, with continuous mindful check-ins.

All: OD increases accessibility to MH services.

### **Spreading the Openness; "it's like a ripple effect" (Jerry)**

All: Ripple effect – spreading the openness.

They find it easier to tell people about their experience after OD

What OD is becomes apparent through your experience of it.

All: shared understanding about how L can be best supported in social network becomes possible in OD.

L: It's hard not being able to include everyone you want in meetings, due to time constraints.

J: Telling friends outside of the family helps them understand.

L&V: Relatives talking with friends about OD meetings has helped them cope.

L & V: L's friends have been interested in OD meetings and willing to hear about them.

V: Some friends of L's have been supportive to her over last year.

Appendix 11: Ethics Approval Letter from City, University of London



Psychology Research Ethics Committee  
School of Social Sciences  
City University London  
London EC1R 0JD

13 March 2015

Dear Jack Closs,

**Reference:** PSYCH(P/F) 14/15 127

**Project title:** What is the experience of peer-supported OD service users?

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

- (a) Recruit a new category of participants
- (b) Change, or add to, the research method employed
- (c) Collect additional types of data
- (d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [REDACTED], in the event of any of the following:

- (a) Adverse events
- (b) Breaches of confidentiality
- (c) Safeguarding issues relating to children and vulnerable adults
- (d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Erika Suchanova  
Departmental Administrator  
Email: [REDACTED]

Katy Tapper  
Chair  
Email: [REDACTED]

Appendix 12: Ethics Approval Letter from South East Coast-Surrey Research Ethics Committee



**NRES Committee South East Coast - Surrey**

Bristol Research Ethics Committee Centre  
Whitefriars  
Level 3, Block B  
Lewins Mead  
Bristol  
BS1 2NT

Telephone: [REDACTED]

01 June 2015

Mr Jack Closs  
[Researcher's address]

Dear Mr Closs

<b>Study title:</b>	<b>What is the experience of peer-supported OD service users?</b>
<b>REC reference:</b>	<b>15/LO/0733</b>
<b>Protocol number:</b>	<b>PSYCH(P/F) 14/15 127</b>
<b>IRAS project ID:</b>	<b>172997</b>

Thank you for your letter of 29 May 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, [REDACTED]

[REDACTED] Under very limited circumstances (e.g. for student research

which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [REDACTED]. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

## Ethical review of research sites

### NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Study Poster]	1	13 April 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of insurance]	1	01 August 2014
Interview schedules or topic guides for participants [Interview Schedule]	1	13 April 2015
IRAS Checklist XML [Checklist_23052015]		23 May 2015
Letter from sponsor [Sponsorship letter]	1	13 April 2015
Other [Reviewed REC Form wording [A6-1]]	2	21 May 2015
Participant consent form [Participant Consent Form]	1	13 April 2015
Participant information sheet (PIS) [(Tracked Copy)]	2	21 May 2015
Participant information sheet (PIS) [(Clean Copy)]	3	21 May 2015
REC Application Form [REC_Form_08042015]		08 April 2015
Referee's report or other scientific critique report [City University Ethics approval letter]	1	13 March 2015
Research protocol or project proposal [Research Protocol]	1	13 April 2015
Summary CV for Chief Investigator (CI) [CV CI]	1	13 April 2015

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## After ethical review

### Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

## User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

## HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

<b>15/LO/0733</b>
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<b>Please quote this number on all correspondence</b>
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With the Committee’s best wishes for the success of this project.

Yours sincerely



pp Dr Mark Atkins Chair

Email: [REDACTED]

*Enclosures:* “After ethical review – guidance for researchers” [\[SL-AR2\]](#)

*Copy to:* Professor Martin Conway, [REDACTED]  
[Name of a London NHS trust research manager and her email address]



## **SECTION B: JOURNAL ARTICLE**

### **THE EXPERIENCES OF FAMILIES USING OPEN DIALOGUE IN THE NATIONAL HEALTH SERVICE**

## **The Experiences of Families Using Open Dialogue in the National Health Service**

Word Count: 5987

Suggested Running Head: Families' Experiences of Open Dialogue in the NHS

*Keywords:* Open dialogue, experience, families, NHS.

Authors: Jack Closs; City, University of London; [jack.closs.1@city.ac.uk](mailto:jack.closs.1@city.ac.uk)  
Dr. Aylish O'Driscoll; City, University of London; [Aylish.ordriscoll.2@city.ac.uk](mailto:Aylish.ordriscoll.2@city.ac.uk)

## **The Experiences of Families Using Open Dialogue in the National Health Service**

This research developed understanding of the experiences of five families who had been using open dialogue (OD), an alternative approach to mental healthcare for severe mental illness, in the United Kingdom's National Health Service (NHS). Each family was interviewed as a group, and critical narrative analysis was used to analyse each family's experience. This resulted in a series of idiographic narratives, which were then considered from the theoretical perspectives of empowerment and objectification. This paper focuses on how the narratives of two of the families interviewed can be understood from the perspectives of humanistic psychology and compassion. Applications for the further practice of OD are considered. Applications for professionals interested in systemic practice, or in working with severe mental illness are also considered. Ideas for future research are suggested.

### **Practitioner Points**

- Understanding the therapeutic relationships facilitated by OD as humanistic, and that they encourage compassion, may help in understanding their development and significance.
- The use of OD may encourage the development of validating therapeutic relationships within the wider social networks of families.
- The findings may help professionals working in similar NHS settings to consider incorporating humanistic, compassionate and systemic approaches into their practice.

## **Terms Used**

I use the term 'service-user' to refer to a person with mental illness. I use the term 'OD user' or 'user' to refer to any non-professional user of OD.

## **Introduction**

Seikkula (2015) described how OD was based on the Need-Adapted Treatment model for psychotic patients and their relatives, a systemic and psychodynamic approach developed in Finland in the late 1970s (see Alanen, 1997). This emphasised the unique process of each person's treatment and how it should be tailored to the person's needs. From 1981 to 1987 the Finnish National Schizophrenia Project resulted in community crisis teams becoming available to 50% of the country (Tuori et al. 1992). In order to better engage families, professionals began making less of an attempt to implement change in the family: in other words 'doing to' practice was gradually replaced with 'being with' practice. In this mental healthcare context, not only was there a need for a model of co-ordinating such care, but there was a need to understand the process of the more collaborative form of dialogue that was being used. Within this context, OD was developed.

Seikkula described OD as "not diagnosis specific, but an entire network-based treatment that is especially practical in crisis situations" (Seikkula, 2015). It focuses on the development of dialogical dialogue, which he explains as follows: "Monological dialogue refers to utterances that convey the speaker's own thoughts and ideas without being adapted to the interlocutors. One utterance rejects another one. In dialogical dialogue utterances are constructed to answer previous utterances and also to wait for an answer from utterances that follow. New understanding is constructed between the interlocutors" (Seikkula, 2002). The intention is to achieve positive change through dialogical dialogue (Seikkula and Trimble, 2005). Razzaque and Stockmann (2016) highlight how, of the seven guiding treatment principles of OD (see below), one to five are relevant to the organisation of mental healthcare, and six and seven are related to the actual practice of OD. These principles have been fully integrated into the management of the entire social and healthcare service in Finland (Seikkula et al. 2003).

The seven principles of OD are as follows:

1. Immediate Intervention: The person in crisis is met by a professional team within 24 hours of referral, with the aim of preventing admission to hospital.
2. Social Network Perspective: The most significant people in the person's social network are gathered.
3. Flexibility and Mobility: The type and context of therapy is adapted to the need. Treatment planning commences more formally once the crisis has abated.
4. Responsibility: The first mental healthcare professional contacted has responsibility for organising the first meeting. The professional team is then in charge of the entire treatment process.
5. Psychological Continuity: The same multidisciplinary professional team works with the social network throughout the entire treatment process, for as long as the crisis requires.
6. Tolerance of Uncertainty: Time is taken to jointly discuss important decisions; for example, whether to use medication is something that is discussed over several meetings. Through meeting as often as required, relationships are developed in which all parties can feel safe.
7. Dialogism: Dialogical dialogue aims to increase OD users' understanding about the mental illness and to increase in their sense of identity, or 'agency'.

### The Introduction of OD to the NHS

Systematic reviews of the research into the effectiveness of conventional NHS community mental health services highlight the limited data available, and indicate a need for more research, in order to be able to make stronger claims about their effectiveness (Marlone, Marriott, Newton-Howes, Simmonds, and Tyrer, 2007; Marshall and Rathbone, 2011; Murphy, Irving, Adams, and Waqar, 2015). Razzaque and

Stockmann (2016) observed that most NHS mental healthcare is tailored to the service-user's needs rather than the needs of the social network more broadly. They identify how NHS professionals tend to approach their work using 'templates and internal algorithms' to help them decide how to respond to people: which information needs imparting and which needs extracting. This is akin to the 'doing to' or monological approach, rather than the 'being with', or dialogical approach, mentioned earlier. By focusing on supporting a social network via dialogical dialogue, rather than on offering healthcare to an individual in a monological manner, OD offers the NHS an alternative approach to mental healthcare. The distinctiveness of OD to current NHS services is supported by perspectives from professionals and service-users (Razzaque and Wood, 2015). Since 2015, NHS trusts have been piloting OD in several community mental health services for severe mental illness (SMI).

It is anticipated that a national randomised-control trial of peer-supported OD in the NHS will commence in 2017 (Pilling, 2016), but, at present, there is a gap in the published research on the experiences of OD users in the UK. By producing idiographic knowledge about experiences of families of NHS OD, I hope to raise further research questions that may need to be considered during the ongoing use and development of NHS OD. My argument for the value of service-user experience research is based upon two assertions. The first is that understanding service-user experience is valued by NICE (2011) as a method of improving mental healthcare standards. Indeed, including the experience of service-users in the design of outcome measures which will determine the funding of services, has recently been recommended (Mental Health Taskforce, 2016). This would bring service-user experience to the very forefront of how NHS services are commissioned. Funding based on service-user experience may become as important as funding by assessment of the published results of treatment. The second assertion is that, by helping the voices of these service-users and their families be heard through this research, I hope, to encourage the further development of OD, thereby respecting the rights of service-users to control over the support that they receive and, thus, to equal participation in society (United Nations, 2006).

## Literature Review

In Finland, Seikkula (2002) used sequence analysis (Leiman and Stiles, 2001) to identify pertinent episodes in OD meeting transcripts. In the good outcome cases, (improved vocational status and reduced psychotic symptoms) the service-user and the family members dominated quantitatively ('spoke' most) and dominated semantically (introduced 'new content' most) in more sequences than in poor outcome cases. Compared to poor outcome cases, in good outcome cases there was more use of symbolic (non-literal) language than literal language, and more dialogical dialogue than monological dialogue. In Norway, Ropstad (2010 - cited in Buus et al. 2017) and Grosås (2010 - cited in Buus et al. 2017) found that inner dialogues (private intrapsychic thoughts) were more frequent in dialogical than monological dialogues. Lidbom, Bøe, Kristoffersen, Ulland, and Seikkula (2015) have suggested that inner dialogues broaden a person's perspective of the meaning that they attribute to a topic. In a reciprocal relationship with inner dialogues, outer dialogues provide new language for inner dialogues. Brottveit (2013 - cited in Buus et al. 2017) identified how significant moments of change in OD related to emotional self-disclosure and conflict with others. It would seem, therefore, that dialogical dialogue is a vital component of OD.

User dissatisfaction with OD due to uncertainty about its process has been highlighted by studies from Norway (Holloway, 2009 - cited in Buus et al. 2017), Denmark (Johansen and Bille, 2005 - cited in Buus et al. 2017), and the USA (Gordon, Gidugu, Rogers, DeRonck and Ziedonis, 2016). The latter two studies also found that families felt unclear about their treatment at the end of OD meetings. The unpredictable nature of dialogue has been identified as particularly threatening for those suffering from trauma (Kamya and Trimble, 2002) and it has been suggested that social network members prefer monological dialogue at times of crisis because of its greater predictability. This would suggest that OD is inherently anxiety-provoking. Qualitative research suggests, however, that OD has been generally appraised as an acceptable approach by its users in Norway, Denmark (Jensen and Jensen, 2001; Balleby and Søbberg, 2012; Søbberg and Balleby, 2012 - all cited in Buus et al. 2017), the USA (Gordon et al., 2016), and Australia (Hartman and De Courcey, 2015). The quality of relationships within social networks was identified as having improved through OD, by users in Denmark (Thylstrup, 2009 - cited in Buus et al. 2017), and Norway (Settem, 2008; Brottveit, 2002 - cited in Buus et al. 2017).

Using a grounded theory approach (Corbin and Strauss, 1990), Piippo and Aaltonen (2008; 2009) developed a theory from qualitative interview data, collected from 22 service-users who were interviewed about their OD experience in Sweden, six months after commencing OD, which suggested that involving family members in meetings led to users feeling safer and more able to cope. This finding may relate to the trust, honesty, respect and democratic power distribution that these authors identified in OD. Conversations in OD which were open and reflexive were identified as useful, with trust and honesty being essential. They found that trust increased when service-users felt more autonomous and that power was felt to be distributed evenly between professionals and OD users in such situations.

Research has also attempted to understand OD users' experiences of both relationships and meaningful dialogue in OD, from an epistemological position which is consistent with OD's assumption that experience is developed via dialogue, in a particular social context. Bøe et al. (2015) used a dialogical approach to qualitative analysis (Sullivan, 2012). New meaning forming in dialogical conversations was interpreted as resulting from the inherent ethic in such conversations of attending to, and valuing, others. This research emphasises how meaningful dialogue is related to respectful relationships.

In summary, the above research on the OD process suggests that supportive and helpful relationships have developed in OD between users and professionals, and, also, between users. It suggests that OD may have applicability across mental health services, but that more research is necessary to achieve more comprehensive understanding of the implications of OD in different contexts for its users, and the part played by the process of dialogue in this experience. The small number of studies available, and the limited amount of information available about their methodologies, reduces what can be said with precision about the experiences of those who have participated in them. The qualitative methodologies used limit consideration about what this research might mean in respect of other OD users to speculation.



## **Methodology**

### Aims

I aimed to answer the following research question: ‘How do families experience OD in the NHS?’ I wished to develop a descriptive, rather than an explanatory understanding of the lived experience of OD, via analysis of each families’ co-constructed narrative of their experience. I wanted to explore how these narratives might be further understood from the perspective of critical social theory. I hoped to include analysis of participants’ experiences since they had started using OD, of their relationships with each other and with professionals, and of how they have understood the mental illness in their family.

### Epistemology

The epistemological position I took was based upon the ontological assumption that reality is, at least partially, determined in dialogue. The social structures, like families, healthcare services or the illness narratives available, which form the contexts of these dialogues were assumed to exist. In accordance with this, I took a contextual constructionist epistemological stance (Lyons, 2007), which assumed that participant experience would, at least partially, have been determined in dialogue, and that it would be relative to the particular social context of each dialogue. Crossley (2007) argues that contemporary psychology needs narrative psychology to bridge the contextual social constructionist understanding of experience and identity, with that of “the essentially personal, coherent and ‘real’ nature of individual subjectivity.”

### Methods

*Inclusion Criteria:* Service-users needed to be suffering from SMI and to currently be using a ‘crisis resolution home treatment’ team or a ‘community mental health’ team (CMHT). Given the inclusion criteria of these services, all service-users would be 18-65 years old. Their relatives could have been of any age. Service-users had to be considered by their care co-ordinator to have had the mental capacity to decide to participate.

*Exclusion Criteria:* I did not ask service-users who were still acutely unwell, as judged by their care co-ordinator according to their level of disorientation and risk, to participate. This was because their illness and risk may not have been managed safely enough, given my limited resources as a researcher. The interview could also have been distressing for

an acutely unwell service-user. Participants who did not speak fluent English were not asked to participate.

*Recruitment:* Professionals working with potential participants agreed to offer information leaflets about the study to them. Participants then gave permission for me to contact them. I then provided them with more information about the study, so that they could give informed consent to participate.

*Sample:* Families were recruited from a London NHS CMHT (see Table 1 for the demographics of the two families discussed in this paper). The names used are pseudonyms.

<b>Families</b>	<b>Ethnicity</b>	<b>Age</b>	<b>Service-User</b>	<b>Diagnosis/es reported by participants</b>
<b>1) Mary and George</b>	Both White-British	49, 52	Mary	Bipolar Disorder
<b>2) Laura, Vivienne and Jerry</b>	All White-British	35, 64, 64	Laura	Bipolar Disorder

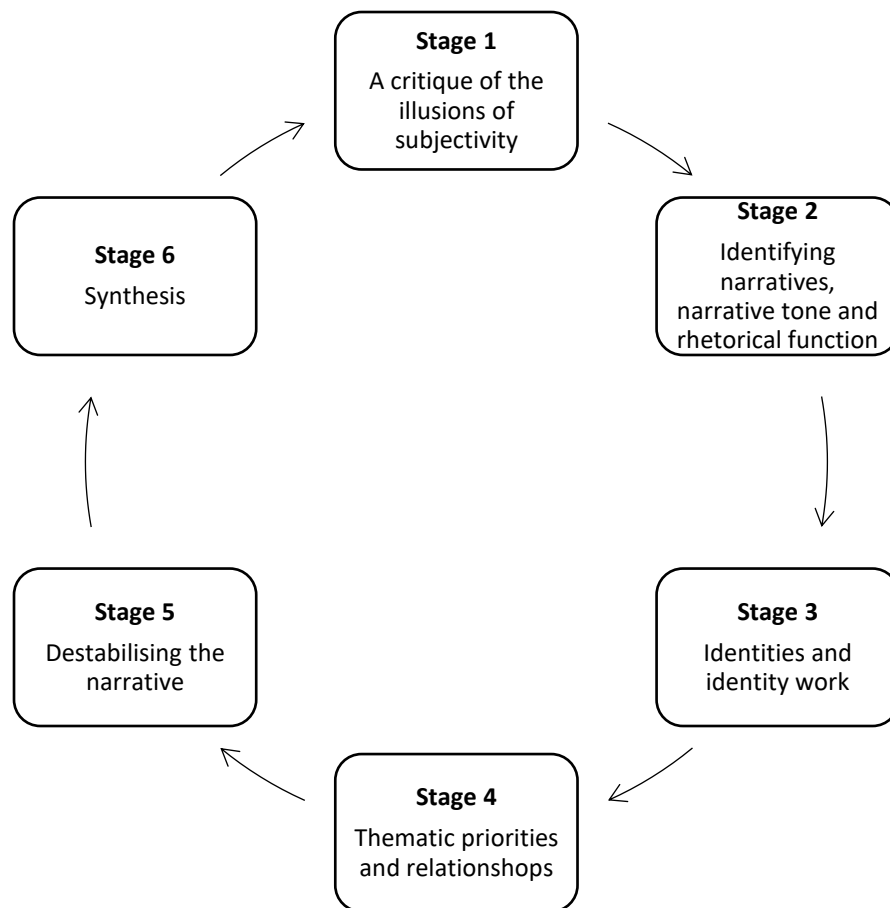
**Table 1: Participant Demographics**

*Group Interviews:* Each family of participants was asked to attend a group interview, consisting of that family of OD service-users only, to talk with me about their experiences of being OD users. Families one, two and five choose to be interviewed at their homes; families three and four choose to be interviewed in a CMHT clinic. I used a semi-structured interview schedule, which included questions about the experiences of the family of the relationships with each other and professionals, and about their experiences of understanding mental illness. The schedule was based upon two key principles: 1) Non-leading and open questions, so as not to predispose any experiences I might be told about and 2) A schedule with broad and open questions, with enquiries into how participants' experience had been over time, to provide an open space in which participants might feel able to tell me their stories of OD. After the interview, each

individual service-user and each family were given the opportunity for a separate debrief meeting with me.

*Interview Schedule:* Although I had been interested in using a narrative form of enquiry, I was unsure whether I would collect narrative data due to the vulnerabilities of my sample and the group interview approach. Indeed Riessman (2008) explains how trauma can limit a person's ability to narrate, Kitzinger (1994) suggests that dominant group norms may silence individuals who would otherwise dissent from this norm, and Marian (2010\*) suggests that people may not wish to discuss their experiences with relatives who may have played a part in their traumatic history. I wondered, therefore, whether the family interview approach I wanted to take might hinder the co-construction of narratives. I was also unsure about whether participants' discussions of their experiences would include reflection on my particular interests. I, therefore, decided that a semi-structured interview could help me to achieve my research aims and that it might help facilitate the co-construction of narratives of experience.

*Analysis:* Critical narrative analysis (CNA) (Langdridge, 2007) provided a relatively clear set of methods for analysing aspects of narrative content and form, in relation to the social contexts of narratives, with the inclusion of critical social theory to further understand these contexts and the subjectivity of the researcher. Having read Langdridge's (2007) worked example of CNA, it was clear to me how this method could be used to explore aspects of participant experience, via analysis of their narratives, and how these methods could be tailored to the individual study. The inclusion of critical social theory seemed useful in helping me identify my subjective position as a researcher and the contextual factors that might be affecting how participants constructed their experience via narrative. Critical narrative analysis was also consistent with my epistemology. Six stages of CNA are described by Langdridge (2007) (see Fig.1 for an outline of these).



**Figure 1: Stages of CNA (Langdridge, 2007)**

Whilst identifying the key narratives that each family seemed to be co-constructing, I noticed how families presented these in a piecemeal and only partially sequential manner. By cyclically returning to the interview text, and by keeping each family's key narratives and master narrative in mind, I realised how the narrative themes I had identified could be used to order each family's journey through OD chronologically. Langdridge (2007) justifies adaptations of CNA that aid the construction of knowledge, such as this. I then considered the narratives from the theoretical perspectives of empowerment and objectification. Given the breadth of my findings, I planned to synthesise them further in the discussion.

*Reflexivity:* I used a reflective journal and Foucault's (1988) critique of the power of social structures, such as models of healthcare, to help me to consider the role of my subjectivity in this research.

## Ethics

Ethics approval was granted by City, University of London and by the National Research Ethics Service in 2015.

## **Analysis and Discussion**

### *Humanistic Therapeutic Relationships*

I define a 'therapeutic relationship' as an interpersonal relationship which has some form of therapeutic outcome. Families described therapeutic relationships as having developed with professionals in OD and, also, as having developed between each other, and between them and their wider social network. Families' narratives suggested that valuable relationships have developed since OD due to a culture within OD of valuing the service-user's mental illness experience, of trusting and respecting the equally valid perspectives of everyone in the meetings, and of having adequate time to talk, in order to allow for a mutually developed understanding about the mental illness. Humanistic approaches to psychotherapy focus on the capacity of people to make choices in order to reach their 'full potential', as well as emphasising the respect of others ("Different approaches to psychotherapy", n.d.). The relationships families described as forming in OD can be conceived of as humanistic therapeutic relationships, which, as in person-centred therapy, include unconditional positive regard for the other, being authentic and being empathic (Rogers, 1957/2007).

The initial anxiety families portrayed in their narratives is supported by previous research (Holloway, 2009; Johansen and Bille, 2005 - both cited in Buus et al., 2017; Gordon et al., 2016). This anxiety can be understood as a need for a trustworthy and secure interpersonal foundation to enable them to explore their mental illness concerns (Byng-Hall, 1995). George explained how the "amazing" optimism of the psychiatrist in OD (unconditional positive regard and belief in Mary's potential) led to him and Mary suddenly having hope. Laura and her family described how the genuine interest and support of OD professionals in Laura's experience (authenticity, unconditional positive regard and empathy) enabled her to let go of her anger, and to consider how she could take more care of herself. From a person-centred therapy perspective (Mearns and Thorne, 2006), families can be identified as having demonstrated their individual needs

for particular conditions for psychological growth, and how these needs were accommodated by the humanistic therapeutic relationships available in OD.

Schmid and Mearns (2006) suggest that, by using positive regard, authenticity and empathy, to '*be with*' a service-user, and to have a mutual exchange of views in dialogue, in which the therapist is '*counter to*' the service-user, a personal and co-created meeting at '*relational depth*' (Mearns, 1996) can occur, which enables recovery from mental illness. Laura and her family describe how the free-flowing and supportive nature of conversation in OD allowed for important topics to be explored usefully together, from several points of view (a personal and co-created meeting), which led to relationships becoming more personal and to greater understanding about the mental illness (or relational depth). Mary and George explained how the non-judgemental (or unconditional) context of OD empowered them to talk more about how they feel in relation to the mental illness, which, Mary explained, has led to her feeling more deeply understood as a person (relational depth). Humanistic therapeutic relationships could be said to have led to the flow of honest and personal dialogue valued by both these families. The finding that this open communication is facilitated in OD is consistent with the dialogical sequence analysis research described above (Seikkula, 2002; Grosås, 2010 - cited in Buus et al., 2017; Ropstad, 2010 - cited in Buus et al., 2017; Lidbom et al., 2015).

The idea that relationships in which people can be honest, are spread via modelling (Rogers - cited in Kolden et al., 2011), provides a useful perspective for considering how therapeutic relationships, within the narratives, seem to have developed across the social networks of the families. As well as the strengthened family relationships reported by Mary and George, Laura and her family explained how supportive relationships had spread across their social network since OD. Rogers and Traux (1967) describe a therapist coming into direct contact with their client without pretence. Indeed, both Mary and George, and Jerry and Vivienne, explained that the deep bond they have with their OD team is akin to friendship. It is, perhaps, these relationships with professionals, which involved trust, respect, and love - akin to friendship (Seikkula and Trimble, 2005), which led families to feel that their mental illness experiences might also be validated by others, in such relationships, in their wider social networks. If these more open relationships are beneficial, perhaps due to their more intimate and supportive nature,

then social cognitive theory (Bandura, 1986) would suggest that they would continue spreading. Perhaps, this is what has led to the increased public receptivity of mental healthcare in Finland (Seikkula, Alakare, and Aaltonen, 2011).

### *Facing the Unknown With Compassion*

Open dialogue users accepting themselves and others compassionately can be considered to be an attitude encouraged by humanistic therapeutic relationships, which further enables families to share their experiences and to learn how to best cope with mental illness, despite the ambiguity and anxiety they faced in OD. Neff (2003) identifies compassion as involving kindness, common humanity and mindful acceptance. 'Kindness' refers to being kind and warm towards one's difficulties, rather than harshly self-critical. 'Common humanity' refers to understanding one's difficulties as being related to the human condition, rather than as something that is isolated from this and as something of which to be ashamed. 'Mindful acceptance' involves being aware of one's difficult thoughts and feelings with acceptance of their presence, rather than necessarily incorporating them into one's identity. Compassionate attitudes seem to have helped service-users to tolerate the uncertainty of discussing their mental illness in OD, and to have helped families to extend their understanding about mental illness.

In Mary and George's narrative of their OD experience, they develop the idea that Mary is no longer "ill", and that, rather than there being anything "wrong" with Mary, the main problem prior to OD was that she felt unable to talk about her traumatic history. Mary's difficulty, thereby, became more relatable to the human condition. This more compassionate attitude, which is developed in this narrative, can be understood as having been encouraged by the apparent humanistic faith that Mary's OD professionals had in Mary's capacity to decide for herself how to understand her difficulties in order to reach her 'full potential'. Laura describes how she felt able to talk about her experiences of mental illness in OD due to the supportive relationships with professionals. By doing so, she became mindfully aware of the thoughts and feelings related to her mental illness, rather than perceiving them as part of her identity. In her, and her family's, narrative, it appeared that her parents were also able to identify this difference. In understanding the origins of her anger, as related to not being heard by

her previous mental healthcare, Laura's distress also became more relatable to the human condition.

By sharing their mental illness experiences within OD meetings, families allowed each other to develop a more mutual understanding of the illness, as was found by Piippo & Aaltonen (2008; 2009). Subsequently, they described situations in which they had adapted their lives to cope more effectively with the illness, as was found by Brottveit (2002 - cited in Buus et al., 2017) and by Settem (2008 - cited in Buus et al., 2017). The compassion between professionals and OD users, and within families, seemed an important part of the development of this dialogue. By having their experiences accepted and understood empathically, by both professionals and family members, within OD meetings, service-users' experiences were recognised as a part of the human condition. Rather than being afraid of, or anxious about being repudiated for sharing their experience of mental illness, service-users subsequently expressed kindness and mindful acceptance of their mental illness. Family members can also be identified as expressing kind acceptance of their experiences of caring for the service-user. Bøe et al.'s (2015) theory that meaning develops in dialogue because of the ethic of attending to and valuing others supports these findings.

Rather than the service-user's personal insight or understanding, Brottveit (2013 - cited in Buus et al., 2017) suggests that emotional disclosure within the social network in meetings is key. Meaningful change in OD is also considered to happen during exchanges of dialogue in which contributors are simultaneously experiencing inner dialogues (Ropstad, 2010; Grosås, 2010; both cited in Buus et al., 2017; Lidbom et al., 2015). Acceptance of how mental illness affects the service-user and family (kindness and mindful awareness) seemed to be the key component of meaningful understanding in OD for Laura, Jerry and Vivienne, whereas for Mary and George, understanding the mental illness seemed to be associated with a more extended exploration into past experiences (common humanity). Although it was unclear from the narratives I analysed in which way such understanding about mental illness in OD developed, a compassionate attitude in both families can be identified as having helped facilitate meaningful dialogue.



### Applications

For professionals who are practicing OD, the findings of this study may offer additional information about what OD users, with whom they are working, are experiencing. Care in such interpretation, however, must be taken by professionals, as this research only claims to understand the experiences of the families that participated in it. However, the findings may help professionals working in similar NHS settings to think about their OD practice, and may suggest questions which may need to be asked in order to understand it more. Professionals may find it useful to consider their practice from the humanistic and compassion perspectives used in this research.

Other professionals interested in systemic practice or in working with SMI, may wish to consider whether humanistic psychological relationships and compassion may help them to develop their practice. They may wish to consider how the concepts used in this paper can help them to understand their current practice. It seems that humanistic therapeutic relationships and compassion can be adopted usefully within multidisciplinary professional teams and families who are supporting, or living with SMI. Professionals may wish to consider how they can support systemic adoption of these therapeutic methods.

### Future Research

This research was limited by its idiographic design in regard to what it could say about how other families might experience OD. The individual and systemic differences within, and between, the families, particularly differences in mental illness, and relationship dynamics, suggest a need for research into how these differences might be measured, and how the effectiveness of OD might relate to the differences. The imminent NHS OD randomised-control trial (Pilling, 2016), might consider including such an analysis, as well as qualitative measures to explore how these differences are experienced by users in relation to OD. The trial might also, usefully, monitor the degree of positive regard, authenticity and empathy within family relationships, using the 'Barrett-Lennard Relationship Inventory' (Ganley, 1989). The level of self-compassion OD users have could be monitored using the 'Self-Compassion Scale – Short Form' (Raes, Pommier, Neff, and Van Gucht, 2011). These measures could be related to other outcome measures to help determine their significance.

The factors and processes within the therapeutic relationships fostered in OD that lead to social inclusion and recovery seem important to explore further. From their review of the literature available on the use of peer-support workers (PSWs) in mental healthcare, Repper and Carter (2011) conclude that PSWs appear to be more able to “promote hope and belief in the possibility of recovery” than mental health professionals. Given that NHS OD is being developed to include PSWs, it could, therefore, be that research into the ability of this group to promote social inclusion and recovery could be particularly valuable.

## **Conclusion**

This research contributes to the current gap in the literature about the experiences of families using OD in the NHS. It explores how humanistic therapeutic relationships support families in their recovery from SMI, and how they appear to encourage the development of therapeutic relationships in their wider social networks. It explores how humanistic relationships and compassion have helped service-users to discuss and accept their mental illness. What seems crucial is that OD research and practice continues to respect the user’s experience and voice, so that they may continue to be empowered to define what is best for them. I hope that this research will act to amplify the voices of service-users and their families, so that they can be more clearly heard in the ongoing dialogue about the value of OD in NHS mental healthcare.

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## Appendix

### The Journal of Family Therapy's Author Guidelines

#### **Manuscript Format**

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must not** contain author names or any identifiable data.
2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:
  - Title Page: to contain the title of the paper, word count, suggested running head (short title for your paper), key words, author names, affiliations and contact details for the corresponding author.
  - Abstract: on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present. *For tips on optimizing your abstract for search engines please click [here](#).*
  - Practitioner Points: two to six bullet points of no more than 180 characters each (including spaces), up to a total of 480 characters.
  - Organisation of the text: see copy of Journal for the format currently in use.
  - Figures, tables, etc.: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated. These will need to be uploaded separately. Please supply figures in the format in which they were created, if possible.
  - References (in text): These should be indicated by the name and date e.g. 'Carr (2009)'. If more than two authors are listed, cite the reference as 'McHugh et al. (2010)'. Quotations should include page numbers. Websites should also be cited in this way, with a full reference appearing in the References section (see below). Please check all websites are live and the links are correct at time of submission.
  - References: Should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details following the APA style of referencing.

- **Articles:** Altschuler, J. (2015). Whose illness is it anyway? On facing illness as a couple. *Journal of Family Therapy*, 37(1), 119-133.
- **Chapters:** Burnham, J. (2012). Developments in the Social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In I.B. Krause (Ed.), *Culture and Reflexivity in Systemic Psychotherapy. Mutual Perspectives* (pp 139-163). London: Karnac.
- **Books:** Burck, C., & Daneil, G. (2010). *Mirrors and Reflections. Process of Systemic Supervision*. London: Karnac.
- **Web pages** (no author or date identified): Counting the cost: caring for people with dementia on hospital wards. (n.d.) Retrieved from [http://alzheimers.org.uk/site/scripts/documents\\_info.php?documentID=1199](http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=1199). [Cite in text as ("Counting the costs", n.d.)]

For further details, please see the APA Style website:

(<http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx>)

3. The word limit, excluding abstract and practitioner points will vary depending on the type of paper you are submitting. Please refer to the 'Advice to Authors' section below.

4. Style: Whilst Journal style is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

### **Advice to Authors**

The word count for papers does not include tables and figures.

### Research Presentation (3,000-6,000 words)

A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study
- Previous work
- Description of methodology including participants

- Results/Findings
- Discussion of results, including implications for future research and practice

**PAPERS EXCEEDING THE SPECIFIED WORD LIMITS (including references) WILL BE RETURNED TO THE AUTHOR**

**The Professional Practice Component of this thesis has been  
removed for confidentiality purposes.**

**It can be consulted by Psychology researchers on application at  
the Library of City, University of London.**