Alice Wates BA Hons, MSc, PgCert

Exploring depth connections in therapy: Understanding practitioners' experiences of Open Dialogue training

Section A: Exploring the factors which facilitate clients and therapists meeting at relational depth, and its therapeutic effect: A review of the literature

Word Count: 7999 (plus 231 additional words)

Section B: "I've lived that thing that we do with families": understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Word count: 7998 (plus 173 additional words)

Overall word count: 16,401

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2019

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

COVER SHEET

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Date ....06/14/19..

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Acknowledgements

I would like to thank the participants who took part in my research. Many of their motivations to participate were based on a passion for the Open Dialogue approach and its potential to improve the lives of their clients. I hope this project can do justice to their words. I am also sincerely grateful to my supervisors Dr. Jo Allen, Dr. Sue Holttum and Anne Cooke for their support, insight and depth of knowledge. I thank my parents and sister for all their love and care. And thank you to my intentional Brighton family for keeping me smiling throughout.

Summary of the Portfolio

Section A is a literature review of the recently expanding field of relational depth (RD) in therapy. RD is described as a profound feeling of contact and engagement between therapist and client. It has been found to significantly contribute to therapeutic outcome, over and above the therapeutic alliance. The review included 10 studies and explored factors which help facilitate relational depth and the impact on therapeutic outcomes. The literature revealed a diverse range of factors influencing deep connectedness, including both therapist and client factors, as well as lasting positive effects of achieving RD. Further research is required with a broader range of clients and therapists to explore the importance of RD across a wider range of contexts and models.

Section B is a qualitative empirical study utilising Interpretative Phenomenological Analysis to understand the experiences of thirteen practitioners who had undertaken a three-year Open Dialogue (OD) UK training programme. Four superordinate themes emerged: (1) A powerful experiential process (2) Personal therapeutic change, (3) Experiencing deeper and more open relationships, (4) Changing relationships with power in working practice. The findings have implications for clinical psychologists in supporting OD teams and for the content of their own clinical training programmes.

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Section A: Literature Review

Exploring the factors which facilitate clients and therapists meeting at relational depth, and its therapeutic effect: A review of the literature

Word count: 7999 (plus 231 additional words)

APRIL 2019

SALOMONS
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Abstract

The important contribution of the therapeutic relationship to therapy outcome is well established. Recent evidence has also suggested additional benefits of clients and therapists achieving moments of deep connectedness, or relational depth (RD). To date there has been no systematic synthesis within this area of research. This literature review explores potential facilitating factors for RD and the therapeutic impacts of achieving moments of deep connectedness. PsychINFO, Medline, Web of Science, ASSIA, the Cochrane library and Google Scholar were searched for published peer-reviewed journal articles. 10 studies met inclusion criteria. Results suggest multiple factors may contribute to achieving RD within therapy. These include: therapist actions and qualities, client factors, the relationship between client and therapist, context and additional training. Fewer published studies are currently available regarding therapeutic impacts of RD; however, the available evidence suggests both positive effects both within sessions and that these effects endure. Further research is required to explore RD across a wider range of therapeutic models and practitioners, including clinical psychologists. The study has implications for mental health services to attend to client readiness prior to engagement in psychological therapies and for practitioners delivering manualised forms of therapy to prioritise achieving depth relations early in their work.

Key words: relational depth, therapy process, therapeutic relationship, qualitative research

Exploring the factors which facilitate clients and therapists meeting at relational depth and its therapeutic effect: A review of the literature

Introduction

Current context

Research suggests that prevalence rates of interpersonal trauma are significantly higher in individuals with severe mental health difficulties than in the general population (Mauritz, Goossens, Draijer & Van Achterberg, 2013). Friedman (1985) proposes that the therapeutic relationship may offer a unique opportunity for individuals to experience an alternative to the intimacy "rejected or withheld in childhood" (p.50). Some service user accounts describe relationships as forming the core of their experiences in mental health care (Gilburt, Rose & Slade, 2008). A special task force, set up in 2009, has explored the evidence base for relational factors within therapy. Results suggested the centrality of the therapeutic relationship and its interdependence with treatment methods (Norcross & Lambert, 2011).

The therapeutic relationship

Carl Rogers was an early proponent of the centrality of the therapeutic relationship for achieving psychological healing. He described a set of six conditions for therapeutic change in person-centred psychotherapy; (1) psychological contact; (2) a client experiencing a state of incongruence, feeling vulnerable or anxious; (3) therapist congruence or genuineness; (4) therapist unconditional positive regard; (5) therapist empathic understanding; and (6) communication of the therapist's unconditional positive regard and empathy to the client (Rogers, 1957, p..57). Rogers (1957) believed the final three elements to be the most important factors in successful therapy, and considered them the 'core conditions'. Rogers claimed that therapists' embodiment of these core conditions is the mechanism which helps liberate the client to express their true feelings, without fear of judgement.

Common factors

Much debate continues regarding which necessary and sufficient elements contribute to positive outcomes in therapeutic interventions. Common factors theory (Wampold, 2007), originating from seminal work by Rosenzweig (1936) and Frank (1961), suggests that all psychotherapies share “common factors”, which explain their largely equivalent results. Such factors include: client variables, such as willingness to engage; therapeutic alliance, a warm relationship with the therapist and expectations for success (Frank, 1961; Wampold, 2007; Wampold, 2015). Interviews with clients suggest that, at least for some, the quality of the relationship is a principal healing factor in therapy. For example, in a review of five studies, Keijsers, Schaap, and Hoogduin (2000) reported that clients who had undergone cognitive behavioural therapy (CBT) consistently described relationships with the therapist as more important than the techniques used.

The contribution of individual factors has been evidenced through rigorous meta-analyses; for example, therapeutic alliance (Horvath, Del Re, Flückiger & Symonds, 2011) and empathy (Elliott, Bohart, Watson & Greenberg, 2011) have each been shown to correlate positively with treatment outcomes in therapy. In the popular press, journalist Johan Hari (2015) points more broadly to the importance of social connections in healing mental distress, through the mechanisms of empowerment and stigma reduction.

Relational depth

It has been suggested that reaching moments of profound connectedness or relational depth (RD) between therapist and client may also be a unique and important aspect within the therapeutic relationship. Mearns (1996) originally introduced the term RD to highlight the importance of achieving depth, or a particular quality of contact in the context of therapeutic relationships. The concept however remains somewhat intangible (Cooper, 2012). Attempts

have been made to provide greater clarity around the term, in part to enable wider research into its therapeutic contribution. One commonly used definition, offered by Mearns and Cooper (2005, p. xii) defines it as a "state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level."

Mearns and Cooper (2005) focus primarily on the role of the therapist in achieving RD. Sustained, quality achievement of Rogers' (1957) conditions, particularly his final three "core" conditions, is said to lead to the single experience of profound connectedness, or what they describe as meeting at RD. Mearns (2003) also emphasises the role of what Rogers (1986) defines as "presence", where the therapist brings their whole self into engagement with the client (Webster, 1998) and is available and open to all aspects of the client's experience (Bugental, 1978). RD is described as both an important aspect of the therapeutic relationship and believed to demonstrate an "upward extension of the working alliance" (Wiggins, Elliott, & Cooper, 2012, p. 140).

This suggests that therapeutic alliance could be understood as an important, but not sufficient element in achieving RD in therapy. The concept of the therapeutic alliance originates from psychodynamic literature; Zetzel (1956) describes the alliance as, in contrast to the transference, the non-neurotic positive element of the therapeutic relationship. Theorists (Greenson, 1967; Horvath & Symonds, 1991) have focused on the role that having a strong alliance plays in navigating the difficult important tasks of therapy, which may involve immediate discomfort, with the aim of relieving long-term suffering (Horvath & Symonds, 1991).

Much remains unknown about the mechanisms behind achieving moments of RD. Rowan and Jacobs (2002) hypothesise that therapists help facilitate states of RD through their

use of self. The authors suggest that in achieving RD therapists move through three 'therapeutic positions' or levels of empathy. The instrumental stage is mechanistic and relies on techniques, where individuals play the 'role' of therapist. The authentic stage is characterised by therapists bringing their genuine self to foster deeper relations. Finally, the authors believe RD is achieved when the therapist moves into the transpersonal stage with the client; where an altered state of consciousness is achieved through a perceived blurring of boundaries between the self and other by deep empathetic focus.

A possible psychodynamic interpretation of the mechanisms could relate to the sense of profound contact and presence, seen as key to achieving RD, reflecting Winnicott's (1960) description of the good-enough care-giver's attunement to the infant. This allows the development of an authentic "true self" through the infant/clients' own internal and embodied feelings being accurately mirrored by care-giver/therapist. From an Attachment perspective (Bowlby, 1982) achieving RD within the context of a positive therapeutic relationship may involve the possibility of forming a correctional attachment and, by internalising the therapist, the client develops a secure base from which to explore their own distress.

It should be noted that discussions of in-depth connectedness are not unique to person-centred theory and have been conceptualised in various ways across a spectrum of modalities. Mutual interdependence in 'moments of meeting' is discussed within the psychodynamic field (Stern, 2004) and dialogical therapies (Hermans & Dimaggio, 2004) draw upon Buber's (1958) notion of an elevated "I-Thou" relationship being achieved within therapeutic dialogue.

Need for a review on RD

Current empirical data are limited and a significant proportion of studies are unpublished student theses on the topic. RD has been found to significantly contribute to

therapeutic outcome in one unpublished study, even after controlling for pretherapy scores and therapeutic alliance (Price, 2012). Therapists acknowledge its presence in their work; in Leung's (2008) online survey of 140 therapists from a variety of orientations, primarily humanistic, almost 98% reported at least one experience of RD with a client. In contrast, evidence from Morris (2009) suggests that different professional groups may experience RD at different frequencies; in one qualitative study only 50% of clinical and counselling psychologists working in the NHS interviewed identified moments of RD in their therapy sessions.

Mearns (1996) proposed a key therapeutic value of achieving RD is that such an experience rarely occurs in clients' everyday lives. Regarding its therapeutic impact, Wiggins (2012) found that RD was predictive of positive results in therapy, accounting for 10 to 30 percent of overall outcomes. Both therapists and clients report believing that achieving RD has an enduring impact on the therapeutic work (Leung, 2008). Qualitative interviews support such findings: Clients in Knox (2008) reported having greater self-knowledge and feeling more connected to themselves as lasting impacts of meeting at RD in therapy.

Much of what Mearns and Cooper (2005) theorise as facilitating RD relates to the role of the therapist skills in displaying deep empathy and authenticity, while also working in the moment and letting go of techniques to allow deep connection. Mearns and Cooper (2005) also theorise the importance of client factors in facilitating meeting at mutual depth connections. Many of these claims have so far been supported empirically and will be explored in the following review.

Justification for review

To date there have been no published systematic reviews which have applied a rigorous methodological process to synthesising the relevant literature on RD. One

unpublished counselling psychology doctoral thesis (Di Malte, 2016) has reviewed the recent literature as part of work to create a measure of frequency of RD in therapy. The review sought descriptive clarity relating to measure development: “What is RD?”, “Why might it be important to measure?” and “How has RD been measured before?” Another PhD literature review (Knox, 2011) also focused predominantly on the conceptual literature and did not synthesise or summarise the overall results of the empirical studies included. Both reviews could be said to lack rigour, according to the Critical Appraisal Skills Programme (CASP, 2013) checklist for systematic reviews. Cooper (2012) has also drawn together relevant research as a book chapter on RD. None of these papers however used quality standards to assess the studies, including unpublished articles, and the quantitative results of database searches were not provided, undermining the replicability of findings.

Aims

Given there is provisional evidence that RD may contribute significantly to therapeutic outcomes (Wiggins, 2012) over and above the therapeutic relationship (Price, 2012), a better understanding of the current literature is required to explore how RD may contribute to therapeutic clinical work. This study therefore aims to further understand what the current research suggests regarding:

1) What factors does evidence suggest help to facilitate moments of RD?

2) What is the therapeutic effect of achieving moments of RD between client and therapist?

Method

Literature search. An electronic search was conducted using PsychINFO, MEDLINE, Web of Science, ASSIA and the Cochrane Library. The following search terms included: “relational depth” OR “relational connectedness” OR “moments of connectedness” OR “moments of contact”. The terms replicate those used in a related unpublished review (Di Malte, 2016) which was supervised by a key academic in the field, Cooper (see Cooper, 2005; Mearns & Cooper, 2005).

Rationale for search terms. An initial search utilised broader terms such as “therapeutic processes”, “therapeutic alliance” (TA) or “therapeutic relationship” (TR) and this returned +75000 results. It was decided to exclude these terms due to provisional research suggesting RD is conceptually different from TA and offers a unique contribution to therapeutic outcomes (Price, 2012). Mearns (2009) argues explicitly that RD is not the same as TA. The corrective and psychological transformative experiences of meeting at RD can involve a “personal challenge” to clients which can be experienced as uncomfortable (Mearns, 2009), while TA is characterised by clients as nurturing qualities of therapist friendliness (Bachelor, 1995).

Other broader and related terms were considered, such as “empathy”, “acceptance”, “warmth”, “collaboration/partnership”, “trust/feeling safe” or “genuineness”, however these are considered dimensions strongly associated specifically with the TR, evidenced by their inclusion in the Therapeutic Relationship Scale (TRS; Sanders and Freire, 2008) and therefore not exclusive to RD.

The inclusion of search terms “love”, “respect”, “intimacy” or “mutuality” were also considered, due to factor analysis on the Relational Depth Inventory (RDI; Wiggins, Elliott & Cooper, 2012) demonstrating these terms closely map onto the concept of RD. Such terms

however individually also have broad conceptual overlap with other constructs within the TR (see Freire & Grafanaki 2010), therefore were also not included as search terms.

Inclusion criteria:

Papers in the current review were required to meet all the following criteria:

- Published peer-reviewed journal articles, as a means of quality assurance
- Articles which related to psychotherapeutic literature
- Empirical studies
- English language studies

The initial search retrieved 201 papers[1], with no date limit applied. Further articles were sought by hand searching using the reference lists of approved papers, other related conceptual articles and papers which referenced the selected articles, using Google Scholar. Duplicates were first removed, as well as articles which from the titles clearly did not relate to the review question. Abstracts of the remaining studies were read in full. The search produced seven qualitative, one quantitative and two mixed methods studies. The results of database searches and process of study selection are presented in Figure 1.

[1] Latest database search: March 2019

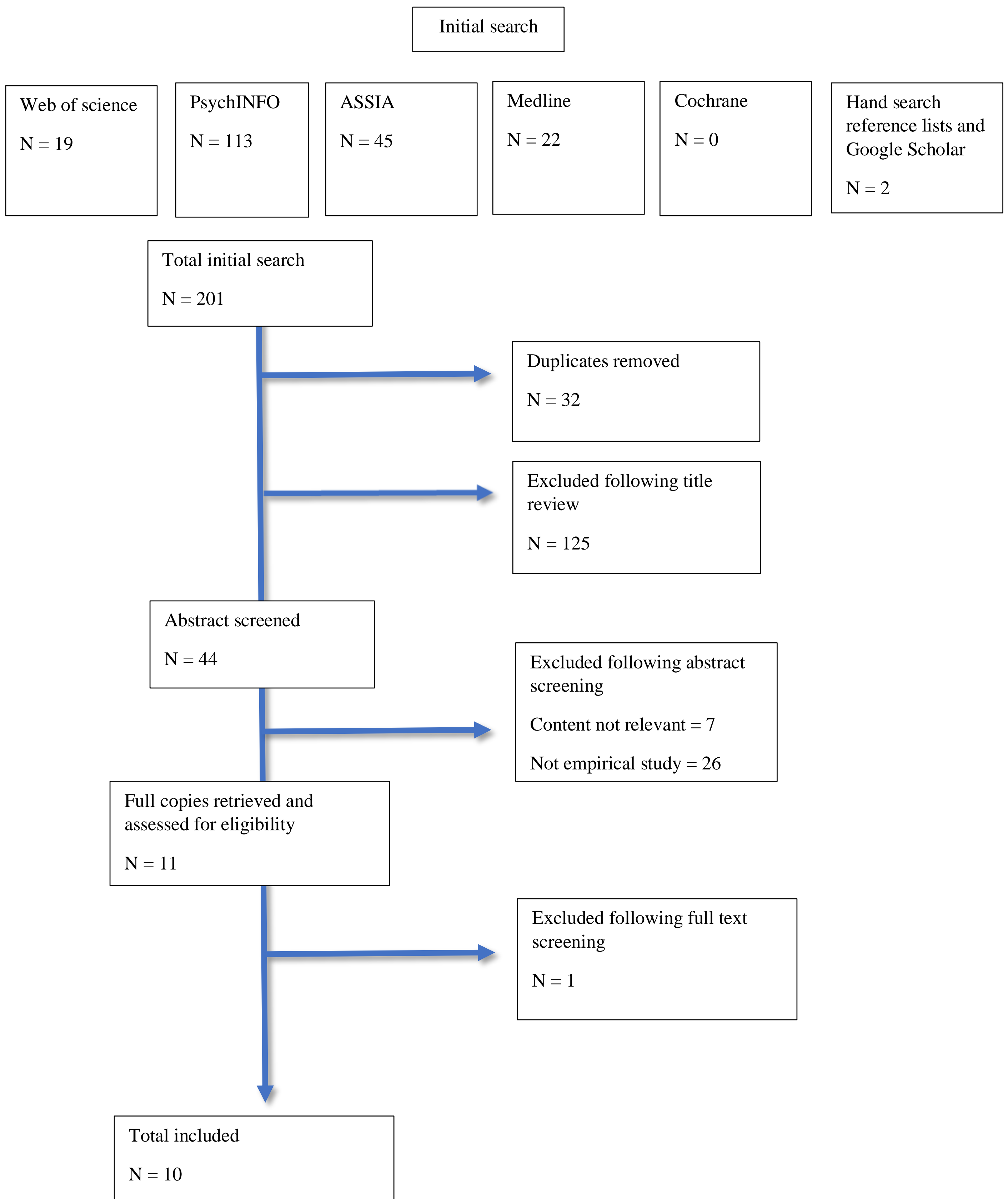

Figure 1: Flow chart depicting systematic literature search

Structure of review. The first section of this review will provide the reader a brief summary of relevant findings from the papers included (see Table 2). Articles will then be critiqued and evaluated with reference to critical appraisal tools. Such tools offer one possible systematic method to evaluate empirical studies. With the presented critiques in mind, questions posed in the review's aims will be considered in turn. Where studies offer partial or tangential answers to the questions posed, the most relevant aspects of the study will be discussed. Finally, both clinical and research implications will be discussed.

Author(s), date and title	Type	Stated aim of the research	Study design	Analysis	Participant information	Key critiques*
1. Cooper (2005) *Therapists' experiences of relational depth: A qualitative interview study*	Qualitative	To explore therapists' experience of meeting clients at levels of RD	Unstructured interviews. Participants were asked to prepare by thinking about examples of working at RD with their clients.	Person-centred and phenomenological approach.	Eight counsellors, seven of whom identified as person-centred. One solution focussed, Average four years of practice (female = 5)	Colleagues interviewed for a pilot project subsequently included in study without potential bias discussed. Combines analyses with no rationale provided.
2.McMillan & McLeod (2006) *Letting Go: The client's experience of relational depth*	Qualitative	To explore whether clients' experience of therapeutic relationship could be interpreted as indicating the presence of RD	Semi-structured face-to-face interviews	Grounded theory	Ten counsellors/ psychotherapists who had themselves undergone at least two episodes of therapy (female = 6). From a range of therapy orientations, majority with person-centred background.	All client participants also therapists themselves. No theoretical saturation point discussed regarding recruitment of participants.
3.(Knox, 2008) *Clients' experiences of relational depth in person-centred counselling*	Qualitative	To explore clients' experience of RD, focussing on specific moments of RD and impacts of such moments	Semi-structured face-to-face interviews	Grounded theory	14 therapists or trainee therapists who had themselves undergone of person-centred counselling (female = 9)	All client participants also therapists. Limited use of quotations which may undermine confidence in findings.
4.(Knox & Cooper, 2011a) *Relationship Qualities that are Associated with Moments of Relational Depth: The Client's Perspective*	Qualitative	To explore, from the clients' perspective, the characteristics of a therapeutic relationship in which moments of RD are more or less likely to occur	Semi-structured face-to-face interviews	Combines phenomenological, grounded theory and thematic techniques	14 therapists or trainee therapists who had themselves undergone individual counselling (female = 9)	All client participants also therapists. Combines analyses with no rationale provided. No theoretical saturation point discussed regarding recruitment of participants. Reanalysis of data collected for previous study.

5.(Wiggins, Elliott & Cooper, 2011) *The prevalence and characteristics of relational depth events in psychotherapy*	Quantitative	To understand prevalence and characteristics of moments of RD in therapy events and to assess quality of new RD measures.	Internet-based survey of client and therapist accounts of therapy, judged by independent raters using Relational Depth Inventory (RDI), Relational depth content analysis and Working Alliance Short Form-Revised (WAISR).	Frequency analysis of qualitative data on RD events. Factor analysis of RDI measure.	343 participants (female = 257). Of which 189 took part as therapists, 152 as clients, 2 did not indicate.	No discussion of power calculation. No discussion of exclusion criteria therefore unclear how representative the sample is.
6.(Knox & Cooper, 2011b) *A State of Readiness: An Exploration of the Client's Role in Meeting at Relational Depth*	Qualitative	Exploring clients' perceptions of factors which facilitate, and the processes and events that led up to an experience of relational depth	Semi-structured face-to-face interviews	Combines grounded theory and thematic techniques described	14 therapists or trainee therapists who had themselves undergone individual counselling (female = 9)	All client participants also therapists. Reanalysis of data collected for previous study. No theoretical saturation point discussed regarding recruitment of participants.
7.(Frzina, 2012) *A case study exploring experience of relational depth between a therapist and a client in a single session recorded during a skills practice*	Mixed methods	How is RD experienced by a client and a therapist in a single therapy session?	Archived recorded skills practice session rated by client and therapist for moments of perceived RD. Followed by discussion of ratings.	Grounded theory using single case study. Each minute of the session was rated on scale 0 to 10 of depth of connection.	Two participants- one was therapist/researcher with CBT background, other was the client, a qualified psychotherapist. Both on counselling psychology doctorate training.	Client also therapist. Use of recorded skills practice leads to potential lack of authenticity in regard to therapy experience. Single case design limits generalisability.
8.(Carrick, 2014) *Person-centred counsellors' experiences of working with clients in crisis: A qualitative interview study*	Qualitative	How do person-centred therapists experience working with clients in crisis?	Semi-structured interviews	Person-centred and phenomenological approach	Ten person centred therapists, with 3-16 years of post-training practice (female = 10)	Snowball sampling- risk of Ps influencing each other. Limited use of quotations which may undermine confidence in findings.

9. Baker (2015) *Working in the present moment: The impact of mindfulness on trainee psychotherapists' experience of RD*	Qualitative	To explore the lived experience and impact of a mindfulness training intervention on practitioners, in particular participants' experiences of relational depth within therapy	Semi- structured interviews	Interpretative phenomenological analysis	Eight masters or doctoral psychological therapy trainees, with a range of theoretical orientations. All participants had undertaken an eight-week mindfulness- based training programme as part of the study	Lack of clear reflexivity statement regarding author's interest in mindfulness approach. Use of combined MBCT and MBSR** training means not possible to know which element was having effect.
10.(Tangen & Cashwel, 2016) *Touchstones of Connection: A Concept Mapping Study of Counsellor Factors That Contribute to Relational Depth*	Mixed-methods	Exploring counsellor factors which contribute to and facilitate moments of deepened connection and relational depth in therapy	Online survey and focus groups	Six step "concept mapping" analysis	20 participants took part in the first round of data collection, 18 in the second and nine in the third. Participants were all at least masters level mental health practitioners from various orientations	No details provided regarding how final set of focus group questions have been analysed. Lack of transparency may undermine confidence with findings. Lack of clear statement of findings, some only appear in discussion.

*Critiques based on CASP (2018) tool for studies including qualitative elements of nine studies. National Institute for Clinical Excellence (NICE, 2012) tool for observational studies used for one quantitative study (Wiggins, Elliott & Cooper, 2011).

** Mindfulness-based cognitive therapy (MBCT) and Mindfulness-based stress reduction (MBSR)

Table 1. Summary of studies included in review

As described in Table 1, four of the ten studies explored issues of RD from the perspective of the therapist while four were from the perspective of the client. The remaining two studies sought the perspectives of both.

Critical analysis of presented studies. Studies containing qualitative elements were assessed using the CASP (2018) checklist (see Appendix A), including the qualitative elements of the mixed-methods study (see Table 1). Each paper was measured against ten questions on the checklist regarding study quality and given a score (Yes = 2, Not Clear = 1, No = 0) out of a total possible score of 20 (see Appendix B).

Overall, studies demonstrated reasonable quality (scores ranging 13-19). Studies' unique strengths and limitations of individual studies are discussed in more detail within the body of the literature review.

Mays and Pope's (2000) offer additional criteria for assessing research and was used as an addition tool to evaluate all qualitative studies' validity and is cited where this adds additional critiques to CASP tool.

A National Institute for Clinical Excellence (NICE, 2012) tool for observational studies (see Appendix C) was used to assess the single quantitative, factor analysis study.

General critique of studies

Participants. One major limitation of client perspectives studies, with the exception of Wiggins, Elliott and Cooper (2011), is they all explicitly sought participants who were themselves some form of therapist or counsellor. The studies gave reasonable justification for this choice, for example, Knox (2008) argues practitioners would be sensitive observers of their own therapy experiences. While reasonable justifications were given, this choice of participants limits the generalisability of much of the available literature. Therapists who have themselves been clients represent a very specific subgroup, who are likely to experience therapy in particular ways. As McMillan and McLeod (2006) acknowledge, participants may have been motivated to overstate experiences of RD with colleagues in the field. The particular nature of these participants should be held in mind when considering this review's findings.

Another critique is that Knox and Cooper's (2011a & 2011b) papers are both re-analyses of data originally reported in Knox (2008). Given the research aims described in the later studies were not ever posed as questions to the original set of participants, the findings may be missing important data regarding the area of interest. In addition, this means almost a third of the studies reviewed here reflect data collected from the same 14 individual participants, limiting the breath of understanding in this area.

Exclusion criteria were not made explicit in Wiggins, Elliott and Cooper's (2011b) quantitative study which raises questions about possible sampling bias in the recruitment of participants, perhaps seeking therapists using certain models.

Methodology. A flaw in many of the studies was the lack of justification for their methodological choices. For example, Knox (2008) and Knox and Cooper (2011a; 2011b) described combining forms of grounded theory and thematic methods of analysis, while providing no epistemological or methodological explanations for such choices. This lack of transparency leads the reader to be unclear about how the data were analysed and therefore the conclusions arrived upon.

In addition, none of the studies that described using a grounded theory approach discussed reaching theoretical saturation in their sampling. Grounded theory method entails the strong interdependence between recruitment and analysis (Straus & Corbin, 1998). Without transparency regarding saturation, claims by the studies to be offering a reliable theory on the phenomenon of interest should be viewed with caution.

Analysis and validity. With respect to Mays and Pope's (2000) criteria, the majority of the studies lacked transparency and rigour regarding their analysis. Only Carrick (2013) discussed participant validation of their findings and none of the authors described the use of a second researcher to rate themes to enhance reliability.

All of the studies provided a reflexivity statement. However, most described their interest in the area of RD but failed to offer further reflections on how this may have influenced their findings. This may be particularly relevant due to many of the researchers having authored textbooks in this nascent area of literature, therefore may be motivated to help legitimise the phenomenon itself.

Critique summary. Overall the majority of studies included appear to be of acceptable quality; however, a number of important critiques should be kept in mind when reading the following synthesis. These centre on client perspectives being largely limited to a specific subgroup who were themselves therapists, papers which used grounded theory failing to demonstrate theoretical saturation being met, a lack of clear methodology and insufficient

details offered in reflexivity statements. Exceptions include Baker (2015) and Carrick (2014) who produced high quality studies, which are further discussed below.

Literature review

Question one: What factors does evidence suggest help to facilitate moments of RD?

Based on the distinct contribution that therapists and clients provide in facilitating RD, findings are broken down across these groups.

Therapist factors

Therapist actions. The active role therapists take in ‘inviting in’ RD with their clients was evident in the literature, largely through their utilisation of their therapeutic skills. Clients described how therapists helped facilitate RD by actively becoming more focussed and expressing a desire to understand (Knox, 2008; Knox and Cooper, 2011b). Slowing the pace of therapy to allow the opportunity for connection was reported to be an important technique to achieve this (Frzine, 2012, Knox & Cooper, 2011a, Tangen & Cashwell, 2016). Cooper (2005), who conducted the first empirical study on RD, sought the views of eight counsellors with an average of four years of practice, seven of whom identified as person-centred. Moments of connectedness were experienced through achieving deep empathy, including the physical expression of “embodied empathy”, described as an internal mirroring of clients’ experiences. It should be noted that it is not possible to extract the causal relationship involved in these experiences; i.e. whether engaging therapeutic skills such as empathy helped facilitate moments of RD or participants experienced empathetic connections through meeting at RD. A limitation of Cooper’s (2005) early exploratory study was the inclusion of colleagues interviewed for an initial pilot study in the main findings who may have been biased by prior informal discussions with the author.

While the use of such therapeutic skills, discussed above, were described as helpful, notably, moments of disconnectedness were portrayed as associated with the therapist ‘working too hard’, for example giving unnecessary clarification, not making sense or appearing nervous (Frzina (2012). Therapists also described RD being enhanced when they let go of agendas, models and techniques (Baker, 2015) which was hypothesised by the study’s author as creating space for mutual connection

Clients appear to value therapists demonstrating authenticity; in moments immediately prior to RD they described perceiving a change in their therapist, such as being “more real and showing more emotion” (Knox and Cooper, 2011b, p.71). In a number of studies, clients described needing to experience the therapist as real and human, rather than be in a professional role (Knox, 2008; Knox & Cooper, 2011a; McMillan & McLeod, 2006). Mirroring clients’ perspectives, therapists also noted that at these moments they would bring more of themselves, such as sharing their own vulnerabilities with their clients (Cooper, 2005) or intentionally using self-disclosure (Tangen & Cashwell, 2016). Without breaching boundaries, participants wanted therapists to go the “extra mile” (Knox, 2008) to demonstrate care and reach deeper engagement (Knox, 2008; Knox & Cooper, 2011a; McMillan & McLeod, 2006). Some described this as bringing a human element to interactions and making the client feel like the therapist was not just doing their job, but showing genuine human caring (McMillan & McLeod, 2006).

Moments of RD may not always be comfortable or positive; some clients experienced deep connection through the therapist making a challenge (McMillan & McLeod, 2006) or taking a therapeutic risk (Knox, 2008, Knox and Cooper, 2011b) although no such example was provided. The actual content of what was considered a helpful challenge was unclear however, as notably offering interpretations appeared to inhibit relating at depth (Knox, 2008; McMillan & McLeod, 2006). This nuanced distinction is explored in the discussion. Timing

of any such intervention aimed at enhancing depth also appears key. Frzina (2012) used a single case study design to analyse moment-to-moment experiences of RD between a client and therapist using grounded theory. Participants were asked to both rate and discuss perceived levels of connection at every minute of their recorded session. The greatest discrepancy in perceived connectedness between client and therapist was found to occur when the therapist prematurely offered a clarification while the client was still making sense of their own words.

Frzina's (2012) study furthers research in the area by uniquely mapping the moment-to-moment levels of connectedness in therapeutic sessions, offering some insight into the possible precipitating factors in facilitating RD. The study is severely limited however by the fact that the recorded session was performed as part of a skills practice exercise where both the client and the therapist participants were trainees in the same cohort of a doctoral psychology programme. This may have led to a level of perceived inauthenticity within the session and arguably impacted the overall findings.

One study suggests that while therapy skills may help facilitate connectedness, depth connection requires also moving beyond such techniques. Tangen and Cashwell's (2016) study used a mixed-methods concept mapping technique to examine the factors that therapists themselves believed to facilitate RD. Participants were asked to generate and interpret statements regarding inviting RD with clients. Statements were subject to quantitative multivariate analysis to sort, rate and cluster. The authors describe how results suggest that therapists occupy all three of Rowan and Jacobs' (2002) 'use of self' positions to achieve RD. Therapists felt they needed both to incorporate both specific engagement skills in line with the 'instrumental' position, as well as occupy the 'authentic' position through practising therapeutic presence. The authors suggest that therapists also described the requirement to achieve the 'transpersonal' position; seen by Rowan and Jacobs (2002, pp. 121) as

engagement with "what is passing between or beyond the client and therapist" through a state of deep focus and honouring the client and their humanity.

While the study used rigorous and transparent methods in the concept mapping process, no details on a set of additional questions asked in a final focus group were analysed. In these groups, participants were asked about their beliefs regarding how well participants thought their responses mapped onto Rowan and Jacob's (2002) therapist use of self. The lack of transparency over analysis may limit confidence in reported findings.

Therapist qualities

Clients in Knox and Cooper's (2011a) study describe the perceived qualities of therapists with whom they believed they had experienced RD. The study is a re-analysis of data previously reported in Knox (2008). Fourteen therapists or trainee therapists who had themselves undergone person-centred counselling were interviewed. A key finding was that in relationships where RD was experienced, clients perceived their therapists to "match" them in some way by possessing similar or complementary personalities, beliefs or age. Clients also described "knowing from the start" (Knox & Cooper, 2011b, McMillan & McLeod, 2006) when there was a deep connection. These findings may serve to partially challenge the perceived 'active' role therapists are believed to play in facilitating RD, as evidenced in the previous section. However, therapist clients may bring something different to therapy compared to clients without therapy training.

Certain therapist characteristics were defined as important, such as being warm and respectful (Knox, 2008; Knox & Cooper, 2011a). In McMillan & McLeod's (2006) study participants evoked descriptions of archetypal parental figures, emphasising the benefits of a "good or ideal mother figure" who could provide security and support. In contrast, dominating "demanding father" therapists were seen as destroying the possibility of RD.

Similarly, power differentials between therapist and client were cited as problematic, with the perception of an over-controlling therapist leading to an absence of RD (Knox, 2008, Knox & Cooper, 2011a).

Client factors

Evidence from studies which focus on clients' perspectives of RD appear to suggest that they can differ from that of the therapist, and also that factors internal to the client play an important role in facilitating such experiences.

McMillan and McLeod (2006) interviewed ten counsellors or psychotherapists who had themselves undergone at least two courses of therapy. Some therapy experiences were current, while others were up to 30 years in the past. Accounts of experiencing RD highlighted a willingness on the part of the client to "let go" and "take a leap of faith" (p.284). Clients saw themselves needing to take the active decision to trust in the relationship and let down their defences, rather than carefully monitoring and controlling disclosures. As discussed, one limitation is that all participants were therapists or counsellors themselves and may therefore have unique experiences of what participants described as "letting go" in therapy, compared to non-therapist clients. Such clients may be better able to trust the process, or, conversely, be inhibited by being hyper-aware of their therapists' technique. Such findings regarding the role of the active client in achieving RD were supported by Knox and Cooper (2011b), with "client readiness" being a key theme, but these participants were also therapists. Most participants attributed RD more to their own actions than to those of the therapist. Readiness was characterised by a proactive decision to open up to, and "let the therapist in".

Of possible significance is that Frzina's (2012) single case study, which mapped moment-to-moment perceptions of connectedness between a client and therapist, did not

report any active elements on behalf of the client in facilitating RD. It is possible that the format of the study affected the focus of participants' reflections i.e. they were asked to comment on observations of a session recording, which may have caused the client to focus on external and observable features of the session rather than internal factors, such as motivation or readiness. More such research is required.

Between the client and therapist; relational factors

While some studies described factors pertinent to either the client or the therapist, many also described facilitating factors related to the quality of the relationship between the two parties.

The experience of congruence and mutual connectedness between client and therapist was perceived to be a key to facilitating RD (Cooper 2005; Frzina 2015). Both clients and therapists describe moments of RD occurring within mutual and reciprocal, close and intimate relationships (Cooper, 2005; Knox, 2008, Baker, 2013). Cooper (2005) describes a complex picture emerging. That of a relational cycle where authentic "co-openness" or "co-transparency" leads to an apparent meta-level understanding on the part of the client (from the therapist's viewpoint); i.e. the "client acknowledged the therapists' acknowledgement of them" (Cooper, 2005, p.92). McMillan and McLeod (2006, p.289) offer a revised definition of RD which takes into account the relational synchronicity required between clients and therapists. They suggest that feelings of deep connectedness arise from a client's willingness to let go of defences and open to another, in the context of feeling deeply cared about and supported by their therapist. This suggests that a client's active letting go may be conditional on their perception of the therapist.

Wiggins, Elliot and Cooper (2011) provide a factor analysis of the Relational Depth Inventory (RDI), a measure of quality of the therapy relationship, with 342 clients and

therapists completing an online survey. The elements most strongly characterising RD by explaining variance, for both clients and therapists, were "love", "connectedness" and "respect". Notably there was no significant relationship between length of therapy and depth of connection. The study demonstrated the reliability and validity of the RDI, did not report their exclusion criteria therefore is unclear if the study demonstrated a representative sample or was biased in any way. The paper extends literature in this area to include the concept of "love" as an important but infrequently discussed factor in RD, although no definition of this concept was provided and requires further research.

Mutual connectedness was characterised by deeply immersive and altered states of consciousness where boundaries between the self and other are broken down. The quality of the relationship was described in spiritual language at times; therapists described the "touching of souls" (Cooper, 2005, p.92) and clients felt a reaching of mystical dimensions (Knox, 2008). Factor analysis of the RDI revealed that experiences of transcendence labelled as "mystical" and "spiritual" emerged as key elements strongly associated with RD within a therapy relationship (Wiggins, Elliot & Cooper, 2011). Across studies, both clients (Knox, 2008; McMillan & McLeod, 2006) and therapists (Cooper, 2005, Baker, 2013) describe entering together into present moment altered states of consciousness. Cooper (2005) notes a correspondence between what therapists describe as RD and experiences of "flow", a concept described by Csikszentmihalyi (2002) as states of deep immersion when engaged in activity, which lead to psychological satisfaction.

Situational and contextual factors

Clients in Knox and Cooper (2011b) described how critical events such as a crisis or trauma in their lives could act as a "catalyst" for the relationship reaching a deeper level. This finding is further evidenced by Carrick (2013) who interviewed person-centred therapists with 3-16 years of post-training practice, on their experiences of working with clients who

are in crisis. While not explored explicitly as an aim in the research questions, all participants described what Carrick interpreted as reaching RD in their work. Counsellors believed that being in a state of crisis led clients to reach a state of openness, which encouraged RD. Participants describe their experience of clients appearing more real and "defenceless". This was believed to lead to deeper engagement and at a quicker pace than their working with non-crisis clients. Notably, participants felt this openness was not a choice on the part of their clients, but was facilitated by the crisis situation, although again it is not clear about the direction of causation with regards to such openness at points of crisis. Carrick highlights the dual nature of crisis working, as presenting both danger and opportunity. These findings may link to evidence cited earlier; that clients believe letting go of their own defences can help facilitate RD.

Carrick's (2013) study was of relatively high quality, demonstrated in part by the author describing the establishment of a pilot project to form a meaningful interview schedule and promoting transparency through inviting participants to review transcripts and analysis. One limitation was the use of a 'snowball sampling' technique where participants are recruited through previous interviewees. This may have led participants to influence each other's views through discussion of the study.

Training

An important conclusion by Baker (2015) was that further training of mental health practitioners can help support therapists to achieve RD with clients. Participants were UKCP psychotherapy or counselling psychology doctorate trainees with a range of backgrounds including CBT and integrative modalities. Participants described how the training helped facilitate what the author describes as "being with versus doing to" (p.7) through a process of letting go of agendas and distractions, which enabled deeper connections. They felt better able to empathetically join or sit with clients' distress through remaining more present-

focused. Therapists also believed their modelling of mindful qualities such as self-acceptance and openness lead to a deeper connection, when clients then adopted similar "ways of being" towards themselves. This study rated highly according to the CASP (2018) checklist and provides a useful contribution to the literature. One limitation Baker (2015) acknowledges is that, due to the mix of MBSR and MBCT it is unclear which elements led to the study's findings.

In a set of focus groups in the final stage of Tangen and Cashwell's (2016) study, practitioners expressed a belief that creating conditions for RD was a trainable skill. The authors suggest this extends the conceptual literature, which they claim emphasises an ephemeral nature to RD. Notably, participants felt that achieving RD also relied on counsellors themselves having the capacity to meet clients at this level, based on the quality of therapists' own relationships, such as with family, friends or supervisors. Notably, this finding may contribute to the debate regarding the requirement to undertake personal therapy during therapeutic training courses which could explore therapists' own attachment (see Bowlby, 1982), currently not a requirement on clinical psychology training programmes. As discussed before, the authors provide no details about the analysis process of their focus group findings which may undermine their validity.

With the evidence so far providing insights into how practitioners may help facilitate RD, this review will now consider how achieving deep connectedness impacts on outcomes within therapy.

Question two: What is the therapeutic effect of achieving moments of RD between client and therapist?

Fewer of the studies included offered findings relating to the second question posed. At this early stage of development in the field there are currently only unpublished

quantitative papers (Price, 2012; Wiggins, 2012) measuring the effect on therapeutic outcomes. Early exploratory qualitative studies offer some insight into the impact of RD on clients' subjective experiences rather than clinical outcomes, although this was not a focus of any paper.

Study participants describe some of the immediate, in-session, impact of RD as having a positive effect on the therapeutic process. Knox's (2008) study of 14 therapists or trainee therapists, who had themselves undergone person-centred counselling, considered reaching RD was a moment of positive change in themselves or the therapeutic relationship. Some described feeling more open to share their "innermost feelings" and able to accept their own vulnerability. Clients also described being better able to access "new material": pertinent content related to their own distress, which may not have been previously accessible (Cooper, 2005; McMillan and McLeod, 2006). Notably, this relates more to therapy process than outcome.

Studies also described the lasting effects of achieving RD in therapy; clients in McMillan and McLeod's (2006) study described as "an enduring sense of the therapist's presence" (p.286) and connection to their therapist between sessions. This continued connection became an internalised resource which was applied when facing emotional difficulties. Clients in Knox (2008) also reported enduring effects of the "healing" relationship where RD had been experienced. In slight contrast to McMillan and McLeod's (2006) findings, where a connection to the therapist seemed to endure, clients instead described an enduring connection to themselves. Clients felt more integrated, "real" and "whole" through the process of being validated by their therapist. Knox (2008) provides very limited use of direct participant quotes to support some of the reported findings, which may lead readers to question the validity and rigour of analysis and therefore findings.

McMillan and McLeod's (2006) study also offers some insight into the possible impact of RD on therapists, who described feeling feelings of satisfaction, happiness and enjoyment in their work. This also appeared to lead to a sense of optimism for clients at these times. Again, it is unclear how, if at all, such positive effects on therapists' experience may impact on client outcomes. It could be hypothesized that such effects help reduce stress through increased compassion satisfaction (Figley, 1995) and allow therapists to remain in their roles and more attuned to their clients.

Potential risks of such deep connections are also noted by McMillan and McLeod (2006) as a small number of clients described relationships characterised by RD as eventually becoming problematic. Clients wanted more from therapists and perceived their maintenance of boundaries as withholding behaviour. This rupture was perceived as providing a diversion to the desired content and goal of the therapy. Notably the negative impact of RD was not reported elsewhere in the current literature, more research is needed in regard to this finding.

Discussion

The aim of this study was to review the entire current body of published empirical literature in the area of RD with the aim of answering two key questions:

1) What factors facilitate moments of RD between clients and therapists?
2) What is the therapeutic effect of achieving moments of RD between client and therapist?

In regard to the first question, the literature provides a rich picture of the multiple factors which may contribute to achieving deep moments of connection within therapy. These include: therapist actions and qualities, client factors, the relationship between client and therapist, context and additional training.

While therapist input remained a highly salient factor in “inviting in” moments of RD, evidence regarding the importance of client factors in facilitating RD extends the early conceptual literature, which predominantly focuses on the perspectives and actions of the therapist (Mearns & Cooper, 2005). The theoretical literature does also however identify the need for “client openness” in order to achieve RD (Mearns and Cooper, 2005). In line with this hypothesis, client readiness (McMillan and McLeod, 2006), timing and willingness to “let go” (Knox & Cooper, 2011b) within the therapy were key themes to emerge from client perspective studies. Notably the direction of causation is not clear, as level of engagement on behalf of the client may also be facilitated by the quality of the therapist. The review’s findings may align with Orlinsky, Ronnestad and Willutzki’s (2004) review of relational factors in therapy, which suggests that the quality of clients’ participation correlates significantly with outcome in therapy.

The literature also suggested subtle and nuanced elements of achieving RD. For example, while clients reported that therapists taking risks and challenging them helped facilitate RD (Knox, 2008), offering interpretations was identified with a perceived lack of RD within the relationship (McMillan and McLeod, 2006). Arguably these two findings may reflect a difference in perceived tone or function of a therapeutic challenge; genuine curiosity may be consistent with facilitating deep connection, whereas interpretations may be experienced as the therapist adopting a “cold” or “clinical” position, which clients in Knox and Cooper, (2011a) experienced in therapy relationships with no RD. Given that interpretative interventions have been evidenced to enhance client’s insight regarding repetitive internal conflicts (Gabbard, 2004), this also raises the possible question of whether it is ever necessary to temporarily suspend attention to RD, in order to facilitate alternative model-specific healing techniques. Alternatively, more research is required to study the timing and sensitivity of interpretations in order to sustain RD.

Overall, it seems that neither therapist nor client factors are independently responsible for facilitating RD. McMillan and McLeod (2011, p.289) offer a definition of RD which takes into account a complex relational interplay, where connection for the client "arises from being willing to let go in the presence of a therapist and from a sense of being deeply cared for". It remains difficult to extract those factors which may play the initiating or causal role in achieving RD; does feeling cared for allow clients to let down defences and 'let the therapist in'? Can therapists' empathy and care only be truly experienced when the client is willing to 'let go'? It is possible that these occur almost simultaneously, as the experience of synchronous "co-openness" was described in several studies. More *in vivo* or audio/video studies of therapeutic interactions along the lines of Frzina (2012) may be required to better understand this.

The current literature provided less data to answer the second question posed by this review, regarding the impact on therapeutic outcomes. Importantly however, clients described a number of positive process-related experiences associated with experiencing RD including an ability to access new material and emotional engagement with their own narratives (Cooper, 2005). This may point to the additional benefits of working at RD in more cognitively based therapies, as emotional processing in therapy is strongly associated with outcome (Whelton, 2004).

Across the literature, two key enduring impacts of experiencing RD emerged for clients. Firstly, they talked of a lasting connectedness where the internalised therapist could be accessed as an inner resource between sessions (McMillan & McLeod, 2006). In psychodynamic terms, this may represent internalisation of the therapist as a good-object which Greenberg and Mitchell (1983) suggest can reshape early relational patterns. Therapist internalisation has been documented elsewhere (Waters, Holttum & Perrin, 2013) and might be an aspect of therapy outcome that requires further investigation across therapies. Secondly,

the experience of being validated by the therapist in moments of RD seemed to provide clients the positive experience of feeling more integrated with themselves (Knox, 2008). The achievement of the authentic “true self” through attunement (Winnicott, 1960) or the healing work of integrating multiple “characters” in the mind through engaging them in external and internal interchange in dialogic therapy (Hermans & Dimaggio, 2004) and may provide insight into the mechanisms through which RD leads to therapeutic change. Overall, more research is required to understand if the positive experiences of RD lead to long-term reduction in distress for clients.

Finally, one possible debate to emerge from the literature was the question of whether the ability to foster RD can be learnt. Some of the literature continues to point towards more intangible, spiritual elements which constitute RD; experiences of transcendence were considered significant factors in the RD construct (Wiggins *et al*., 2011). This aligns with Cooper’s (2012) proposal that the essential elements of RD are hard to pin down and therapeutic change may occur through the very qualities of mystery and surprise. However, a number of studies discussed the use of core therapy skills in facilitating RD and evidence suggests that RD can be enhanced through additional mindfulness training (Baker, 2016). One possible explanation for Baker’s (2016) finding relates to, as Falb and Pargament (2012) argue, the concept of “relational mindfulness”; where mindfulness is practiced in relationship with others through enhancing mutual awareness and attention, and not focused on the individual. Falb and Pargament (2012) suggest this can enhance both qualities of the therapeutic relationship such as empathy and acceptance, while also facilitating spiritual qualities such as transcendence and interconnectedness. The concept of relational mindfulness may be relevant in understanding how the quality application of core therapy skills can lead to spiritual experiences apparently characteristic of RD.

Limitations

One limitation of the review is the quality of the studies included here. While many of them scored reasonably highly on CASP checklist, a number had some critical flaws which may limit this review's findings. Almost a third of the studies used data collected from the same set of participants, which limits the breadth of knowledge in this area. Secondly, most clients' perspectives were a unique subgroup of therapists themselves. Thirdly, issues arose regarding methodology rationale and analysis transparency. Arguably, therefore, the findings reported in such studies should be read with caution before drawing firm conclusions from the data.

A fourth issue is the question of whether studies were reliably reporting the same phenomena, given that the concept of RD remains somewhat elusive. With growing interest in the field of RD, it is possible that researchers may claim to have documented it in their findings without due attention to the nuanced differences which separate RD from similar constructs, such as TR. For example, Carrick's (2013) study reviewed here cites participants' descriptions of "high states of arousal" and "deeper connection" as denoting the presence of RD. While these are both elements of RD, as described by Mearns and Cooper (2005), it is not clear findings fully equated to experiencing moments of depth connection. It was also unclear how the effect of RD was able to be isolated from other aspects of the therapeutic process across several studies.

Finally, there was less data available to answer the second question posed in this review, regarding the possible impact of RD on therapeutic outcomes, although as mentioned previously, there were indications of its possible influence from one unpublished study (Price, 2012). None of the studies reviewed had this as the focus of the study and therefore firm conclusions cannot be drawn based on the findings here.

Clinical implications

Client readiness was cited as an important factor in achieving meaningful engagement in therapy, which may pose a particular challenge for UK NHS mental health services. As McMillan & McLeod (2011) note, the ability to pay will impact on client choice in therapy. In the current NHS funding climate, timing of support is often based less on clients' choice and more on waiting lists, resources or referrals made by third parties based on their services' needs. In the absence of the possibility of real choice around the timing of treatment in the current NHS, services could consider investing in "pre-therapy" interventions which aim to explore and enhance client readiness and improve the possibility of meaningful engagement. This may raise questions about how efficiently resources are currently being spent in public psychological therapy services.

Another important insight to emerge is that RD was seen as absent in experiences with over-controlling therapists (Knox, 2008) and those who were perceived to misuse power (Knox & Coper, 2011a). This suggests the importance of therapists' own self-development to avoid recreating oppressive hierarchies within therapy which impede moments of connectedness. In a feminist response to Rogers' (1957) work, Brown (2007) notes politics is often absent in Rogers' theorising, and that failing to acknowledge discrimination and oppression within therapy can contribute to experiencing "incongruence" within sessions, arguably impacting depth relations.

While still tentative, findings may have implications for manualised forms of therapy which, arguably, place less priority on achieving deep connections with clients than delivering evidence-based techniques. In order to optimise outcomes, practitioners may need to allow more space and time within therapy to achieve RD. This may be needed for clients to 'let go' of protective defences (Freud, 1937) which could undermine the effectiveness of any subsequent therapeutic intervention attempted within the therapy.

Future research

The limited number of empirical studies available for this review highlights the need for more research in this area. A broader range of clients need to be researched. While it was unclear from their methodologies, current studies appear to have focused on clients in private therapy, rather than those using public services, with possibly more acute levels of distress. While Wiggins *et al*., (2011) report no correlation between length of therapy and level of RD, they did not report the average length of therapy in their results. It is possible clients need to be confident of a minimum number of sessions to facilitate a trusting relationship. It would be useful to research what impact working with very time-limited therapeutic interventions, often seen in pressured public health services, has on clients' experience of RD.

So far research has focussed on the perspectives of therapists from person-centred and humanistic backgrounds. Based on Rogers' (1957) claim that the therapeutic relationship is itself the mechanism for healing, achieving RD is arguably considered an emphasis of the work for these approaches. It would be useful to understand similar experiences of a broader range of practitioners, including clinical psychologists, who widely use more manualised interventions, such as CBT. Evidence that suggests only 50% of clinical and counselling psychologists working in the NHS reported recognising moments of RD in their work (Morris, 2009), compared to almost 98% of primarily humanistic counsellors (Leung, 2008), raises questions about what differences across models and setting may be influencing this difference. Further investigation in this area could help explore the relevance of the construct to the work of other mental health practitioners, including clinical psychologists, and how the phenomenon may be enhanced in their work.

Finally, explorative qualitative interviews by Baker (2016) on the impact of mindfulness-based training suggested that such learning could help clinicians achieve greater levels of RD with their clients. Further studies could explore the capacity of alternative

training models to achieve such results. Research into dialogically based therapies is currently limited and arguably can offer potential to enhance RD. For Buber (1952), healing is achieved “through the meeting”, which requires a fundamentally relational stance in therapy. In addition, some of the key therapeutic work and impacts of dialogical therapy, as defined by Hermans and Dimaggio (2004), of moment-to-moment attunement with the client and internal integration, align with those found in this review. Qualitative interviews similar to those conducted by Baker (2016) on the impact of training on practitioners’ personal and professional lives could be repeated for a dialogically-based training course. Given the large-scale UK-based randomised control trial currently being undertaken on the dialogically-based Open Dialogue model, with the aims of reforming NHS mental health care, this would arguably be an important area of investigation.

Conclusion

While currently limited in volume, the current data on RD suggests that it is an important area of research within the psychological therapy literature. Notably, this work is concentrated in the field of counselling literature but so far has been under explored by other disciplines, including clinical psychology. Emerging evidence suggests that achieving RD may be important in facilitating meaningful human connections and may impact at least therapy process and possibly outcome, and therefore the construct appears worth exploring in relation to other types of psychosocial interventions.

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Section B: Empirical paper

"I've lived that thing that we do with families": understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Word count: 7998 (plus 173 additional words)

APRIL 2019

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Open Dialogue (OD) is a social network approach to mental healthcare, originating from Finland. With the approach growing in popularity internationally, a wide range of healthcare professionals are being trained in the method. At the time of writing, the NHS is also piloting the approach across five Trust sites for individuals with severe mental health difficulties. Transformational Learning theory has been used here to understand the process of change which individuals may undergo in adult education. This study used interpretative phenomenological analysis of focus group data to explore the experiences of thirteen individuals who had undertaken a three-year OD UK private training programme. Four superordinate themes emerged: (1) A powerful experiential process (2) Personal therapeutic change, (3) Experiencing deeper and more open relationships, (4) Changing relationships with power in working practice. Findings suggest that practitioners feel more deeply connected to their clients' distress as a result of training. This may have important implications for the role of clinical psychologists in supporting staff in OD teams who may be at greater risk of burnout as a result. The findings also contribute to the Transformational Learning literature regarding how dialogue-based teaching methods can help learners alter their relationship to power in working practices.

Key words: Open Dialogue, mental health staff, staff experiences, transformational learning, qualitative

"I've lived that thing that we do with families": understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Introduction

Current context

A new understanding of recovery has emerged in mental health services, one which emphasises personal and subjective experience rather than a clinical cure from symptoms (Anthony, 1993). While a recovery-orientated definition of mental health has been adopted as policy in the UK (Department of Health, 2011) clinical practice continues to prioritise symptomatic treatment over facilitating approaches which support personal recovery (Perkins & Slade, 2012). Focus on this new understanding of recovery will require a transformation of mental health services (Slade *et al*., 2014). The Open Dialogue (OD) model of mental health care may offer one such alternative approach.

Open Dialogue

OD is a social network orientated system of mental health care developed by Jaakko Seikkula and his team in the Finnish region of Western Lapland in the 1980s. Early non-randomised trials of the approach suggested impressive recovery outcomes for first episode psychosis, with 83% of OD participants returning to work or study (Seikkula *et al*., 2003). A follow up cohort study has suggested long-term positive effects, with significantly lower durations of hospital treatment, use of neuroleptics and disability allowances, compared to controls (Bergström *et al*., 2018).

The theoretical underpinnings of OD, with its lineage in systemic therapies, draw on constructivist thinking and ideas of language and dialogism by Voloshinov (1996) and Vygotsky (1970). OD is most heavily influenced by the dialogical principles of Russian

philosopher Bakhtin (1984). According to Bakhtin (1984), existence itself is dialogical; the "self" is not a self-sufficient concept, but a relational one (Holquist, 2002).

The approach has two fundamental features; firstly, it is a whole system approach which seeks to engage families and social networks around the referred individual, from the outset of their help seeking and beyond (Olson, Seikkula & Ziedonis, 2014). The "needs-adapted" model seeks to flexibly attend to the changing and case-specific needs of the network (Seikkula *et al.*, 2003). The framework also allows the referred individual to receive additional sources of support outside of these "network meetings" if needed, such as individual psychological therapy or occupational therapy. Secondly, dialogical practice is a distinct form of therapeutic conversation enacted within sessions (Olson *et al.*, 2014). Rather than traditional models of therapy, where practitioners may be viewed as "interventionists" with a "pre-planned map for the stories that clients are telling'', the focus for practitioners is to be fully present to the moment-to-moment shifting conversation and offer responses to every utterance within the dialogue (Seikkula, 2011, p.187).

The principle of "tolerating uncertainty", is said to be at the heart of OD and encourages avoiding early diagnosis and minimal use of medication and hospitalisation (Olson *et al.*, 2014). This aims to give teams and networks time and space to construct a new shared language, which "affords a healing alternative to the language of symptoms or of difficult behaviour" (Seikkula & Trimble, 2005). Certain principles of the approach can lead to an apparent restructuring of power within mental health services. For example, the key element of family and network participation from the beginning can help enable non-hierarchical organisation of meetings between staff and service users (Olson *et al.*, 2014).

The model has demonstrated acceptability within the UK; in a study of service users and staff, both groups rated highly the seven key principles of OD, which include

psychological continuity (defined as maintaining therapeutic relationships throughout service experience), flexibility and dialogism (Razzaque & Wood, 2015). Notably, the majority of respondents felt these ways of working were currently unavailable in the NHS. There is a growing interest in OD within the UK including a multi-site pilot study. This involves large scale training of staff across a range of professional roles.

Challenges of integrating OD practice

Schütze (2015) recognises that the shift away from providing predetermined interventions may be demanding for practitioners, such as psychiatrists and psychologists, who are more used to applying academic theories and "expert" models to individuals' distress. Such expert medical models refer to a reliance on guidelines, such as National Institute for Clinical Excellence (NICE), which emphasise the importance of diagnosing, prescribing psychiatric medication and delivering therapeutic interventions. Razzaque and Wood's (2015) survey also revealed both staff and service users anticipated staff attitude change, sharing power and expertise, and organisational change to be among the challenges of integrating OD into the NHS. Even healthcare professionals within needs-adapted OD services revealed they experience challenges maintaining psychotherapeutic attitudes when faced with organisational constraints (Borchers, Seikkula & Lehtinen, 2014).

With such challenges in mind, clinicians being asked to deliver OD may find it difficult to simply apply new learning to their current perspectives and working practices. Training staff in this new approach will play an important role in developing both services and the workforce. OD presents an alternative paradigm to current mental health care and existing staff may need to undergo a transformational learning process, rather than simply adapting current practices. In a reflective piece Seikkula (2011) describes feeling uncomfortable with OD being considered a therapeutic method. Rather, OD requires practitioners to shift to a dialogical "way of life"; one which is interested in the

“intersubjective quality of life as a whole” (Seikkula, 2011, p.191). A useful theoretical framework for understanding significant changes staff may experience as a result of undergoing OD training may be found in the literature on transformational learning, discussed next.

Transformational learning

Mezirow’s (1991, 2000) concept of transformational learning (TL) has been the most commonly applied theory in the area of adult education over the last three decades. The model is applied uniquely to the process and development of adult learning involving critical reflection, and describes how individuals may appropriate new knowledge, revise worldviews and beliefs, and construct new meanings. Influenced by Thomas Kuhn’s (1962) notion of “paradigm shifts”, in the philosophy of science literature, Mezirow (1978; 1991) suggests TL alters an individual’s frame of reference; cognitive structures which organise our understanding of the world. By critically assessing their previously held assumptions and working through a process of synthesising old and new beliefs, learners are said to result in knowledge which is more dependable, inclusive, critically reflective, and more reliable grounds for related action (Mezirow, 1996).

Taylor (2008) notes, while Mezirow’s thinking has dominated the field of TL he developed, other theorists’ have added factors arguably missed by Mezirow. These include contextual and methodological factors in learning. Freire (1970) for example, focuses on critical pedagogy and suggests TL occurs through a dialogue-based approach where greater equity between learners and teachers is encouraged. This places the student at the centre of learning and serves to fundamentally question the assumption that knowledge is objective and is held and transferred by those in power. For Freire (1970) the use of inclusive dialogue in education is modelled as a tool to empower learners to engage in critical thought and in so doing, challenge wider systems of power.

Understanding how educational methods in adult learning can lead to significant changes in beliefs and perspectives may help elucidate how training, including clinically based programmes, may impact on learners. Gravett (2004) argues that processes aimed at substantially modifying previously held knowledge must be intentionally focussed on achieving transformation. The three-year OD training which focuses on critical reflection and personal exploration (see Appendix E) arguably seeks to foster such a learning environment.

Rationale and research questions

With the NHS currently being dominated by a medical model approach, adopting OD within services potentially requires a significant shift in how distress is understood and consequently alleviated by practitioners. Training plays a key role in helping individuals make necessary changes and transitions in their day-to-day practice. A three-year OD training course is currently being offered in the UK, which closely aligns to the original Finnish programme. Gaining a better understanding of practitioners' experiences of OD training could contribute to the programme's integration into, and possible improvement of UK mental health services. Extensive searches of the literature and communication with the originators of OD suggest this has not yet been researched within or outside the UK. Therefore, this study aimed to explore the following questions:

1) What were trainees' experience of attending the three-year Open Dialogue course?
2) How (if at all) participants felt the training affected the way they approach and understand their practice?
3) How (if at all) participants felt training affected their understanding of themselves and their lives?
4) How (if at all) participants felt training affected their experience of encounters with service users?

Method

Design

The study utilised an idiographic interpretative phenomenological analysis (IPA: Smith, Jarman and Osborn, 1999) approach, as a means of understanding the subjective experiences of a sample of individuals who had undertaken a three-year OD training course. IPA was chosen over other qualitative methodologies, such as dialogical analysis (Sullivan, 2011) or thematic analysis (Braun, & Clarke, 2006), as it allows a focus on phenomenological experiences and how participants make sense of these experiences within the complex context of their own personal and social worlds. For example, IPA allowed consideration of the participants' professional roles, and how this may affect their experiences.

The philosophical underpinnings of IPAs "double hermeneutic" theory of interpretation (Smith, Flowers, & Larkin, 2009 pp. 3) was also an important methodological choice. The two stage, "double hermeneutic" approach in IPA acknowledges the multi layered interpretations occurring in analysis.

Traditionally, IPA research has been conducted using one-to-one interviews, but recent papers have argued for its relevance to analysis of focus group (FG) data (Bradbury-Jones, Sambrook & Irvine, 2009; Palmer, Larkin, Visser & Fadden, 2010). Tomkins & Eatough (2010) suggest the epistemological tension and practical implications should be acknowledged at the outset of research; such as whether meaning making is an individual, intrapsychic or a relational process, and consequently whether individual or group level analysis should be privileged. The authors conclude however, if attended to meaningfully, the epistemological complexities of combining IPA and FGs may allow for something "extremely phenomological" which acknowledges the relational aspect of human experience.

Participants

IPA samples are purposively selected, based on participants' likely experience of, and insight into the particular phenomenon being investigated (Smith *et al.*, 2009). Homogeneity or similarity across participants is sought in order to represent a perspective within a particular context, rather than across a population (Smith *et al.*, 2009). Variability in experiences can however be explored in analysis, based on the degree of convergence and divergence across individuals. In this study participants were recruited from a variety of professional roles; however sufficient homogeneity was believed to have been established through their shared experience of training.

While there is no absolute value recommended in the IPA literature, a sample size of between four and ten participants is suggested to elucidate phenomena, using individual interviews (Smith *et al.*, 2009). For FG size there is again no absolute recommendation on numbers, but empirical research in the FG literature suggests groups of four are optimal in idea generation (Fern, 1982). According to Kreuger and Casey (2009), FG researchers should aim for three to four groups to answer the question of interest.

In this study, thirteen participants were recruited across three FGs (see Table 2). Inclusion criteria were that participants:

- Had undertaken the current three-year Open Dialogue training
- Were over 18 years-old

Focus group number	Pseudonym	Gender	Ethnicity	Age	Job Title(s)	Working within UK?	Currently working in NHS?	Working in OD service?	Lived experience of mental health difficulties?
1	Kevin	Male	White British	41	Acting Service Manager/ Nurse	UK	Yes	No	Rather not say
1	Aburi	Male	Black African	**-**	Mental Health Nurse	UK	Yes	No	No
1	Ellen	Female	White British	**-**	Peer worker	UK	Yes	Yes	Yes
1	Llello	Male	White European	59	Psychiatrist	Outside	No	Yes	No
2	Ruth	Female	White Irish	44	OD clinical lead and Lead Clinical Psychologist	Outside	No	Yes	Yes
2	Helen	Female	White other	42	Nurse and Family Therapist	Outside	No	Yes	Rather not say
2	Katin	Female	White British	**-**	Trainer, Consultant, OD Practitioner	UK	Yes	Yes	Yes
2	Sophie	Female	White Finnish	63	Consultant Head Nurse	Outside	No	No	No
2	Paloma	Female	White Danish	56	Psychologist	Outside	No	Rather not say	Yes
3	Andy	Male	English	57	Specialist Nurse and Lecturer	UK	Yes	Yes	No
3	Fred	Female	White British	67	Trainer in POD* and Family Therapist	UK	No	Yes	No
3	Robert	Male	White British	44	Family Intervention Therapist	UK	Yes	No	No
3	Jerry	Male	White Irish	53	Consultant Psychiatrist	UK	Yes	No	No

*POD= Peer-supported Open Dialogue

Table 2. Focus group participant demographics

The 13 participants were recruited out of a total cohort of 28 trainees. All participants reported being personally motivated to undertake training, with the exception of Kevin who had initially been registered by his manager to attend.

Recruitment

The early stages of recruitment were supported and actioned by two of the OD course convenors. They were provided with the study information sheet (Appendix F), which they posted on an online forum for course trainees. Due to their own time constraints regarding supporting recruitment, the course convenors gained the consent of the cohort to be contacted by the researcher, instead of the original plan to wait for trainees to contact the researcher. OD trainees' email addresses were then provided and the researcher then sent further details of the study using the blind copy function to protect trainees' data. This email was sent a total of two times. Individuals were asked to reply directly to the researcher if they wished to take part.

In terms of incentives, participants were informed light refreshments would be offered, in recognition FGs would run immediately after a full day's teaching. Travel expenses up to £10 were also offered if participants were not already on site.

Interview schedule

A semi-structured FG schedule was developed using a review of relevant literature and in collaboration with the expertise of the researcher's three supervisors. For full schedule (see Appendix H).

Question wording	Rationale
1) What made you attend the training?	Based on Kreber's (2004) suggestion that learners' motivation plays an important part in fostering critical reflection, leading to TL.
2) Tell me a little about your current job role and what (if any) training in mental health you received before the Open Dialogue training?	To understand participants' past therapeutic experience and possible theoretical alignment prior to training.
3) What has been your experience of the Open Dialogue training?	Initiating a broad line of questioning to allow participants to offer spontaneous, unbiased reflections of what may have been most meaningful for them.
4) How (if at all) do you feel the training has affected the way you approach your day to day working practice?	Based on assumption that network-based OD approach requires significant shift in working practices and evidence from Razzaque & Wood (2015) that NHS staff and service users anticipated cultural shifts including staff attitudes and sharing power and expertise as challenges to applying OD into the NHS.
5) Have there been any changes to the way you view yourself as a person as result of the training?	Based in part on theoretical and autobiographical discussions of practicing OD by Seikkula (2011) where he postulates that "dialogue is not a method; it is a way of life". In addition, the researchers' assumption that learning about dialogical ways of being and interacting may impact personal relationships outside of the workplace.
6) Has the training impacted on your perception of people who struggle with mental ill-health who are accessing the services you work in?	These questions aimed to help understand if learning about the relational nature of human distress impacted on work with service users.

Table 3. Interview questions and rationale

The structure of the FG was purposively created (Table 3), with more sensitive questions asked later on to support rapport building. Questions were reviewed by a service user who also expressed an interest in OD. This consultation aimed to assess meaningfulness of the research and improve suitability of language around potentially distressing topics.

Ethical considerations

The research project was scrutinised and approved by the Salomons Research Ethics Panel (Appendix D). The work was conducted in accordance with the British Psychological Society (BPS) code of human research ethics (BPS, 2018). Key ethical considerations related to potential distress which may have surfaced for participants around particular questions, such as perceived changes to identity and asking participants to consider their relationship to their own mental distress. To manage this, participants were debriefed at the end and given signposting information for support organisations, such as the Samaritans' phone number (Appendix J). They were also given the opportunity to speak privately with the researcher.

Another consideration was the relatively small size of the training cohort which may lead to participants' responses being more easily identifiable by others. To minimise this risk, participants were given the option to comment on analysis before any public dissemination and state if they felt their anonymity had been compromised.

Focus group procedure

All FGs engaged the following procedure:

- Participants welcomed and provided refreshments
- Purpose of the study explained briefly again
- Participants reminded of confidentiality and provided study information again
- Participants completed written consent and demographic forms (Appendices G & I)
- Participants were asked to collaboratively generate a set of ground rules for the FG
- FG questions asked
- Debrief completed
- Sources of emotional support provided

The three FGs took place during the final week of course teaching, on the same site as the training. These lasted between 97 and 122 minutes. FGs were recorded on audio recorders using a Dictaphone. Visual data were recorded using a camera and backup camcorder in order to capture non-verbal communication.

Data analysis

Data analysis was conducted largely according to the procedure outlined by Smith *et al.*, (2009), with additional reference to Tomkins and Eatough (2010) regarding integrating FG analysis into traditional IPA. Firstly, audio recordings were transcribed verbatim, with data from visual recordings included for additional non-verbal cues afterwards, such as a participant signalling 'inverted commas' with their hands.

Transcripts were then read, and initial notes made focusing on phenomenological content at the descriptive, linguistic and conceptual level. Notes relating to the author's interpretations of the data were also included at this stage.

Analysis began by forming group-level themes and placing these in a table with a number of 'subordinate themes'. A process of abstraction, identifying patterns between themes to create 'super-ordinate' themes, and subsumption, where individual themes themselves later emerge as super-ordinate themes under which related themes are clustered, were conducted. Tomkins & Eatough (2010) then describe creating an "iterative loop" where transcript analysis is repeated at an individual level and used to assess initial group-level analysis (see Appendix N). Each individual's data was temporarily separated, to be read as a whole and compared to the group level themes. Further revisions were made to themes based on this ongoing process. The meaningfulness and distinctiveness of themes were reviewed with supervisors. Participants were also sent themes to check for validity.

Quality assurance

To support the production of rigorous qualitative research Yardley's (2000) quality principles and standards were adhered to throughout the process (see Table 4).

- A bracketing exercise where the researcher reflected on and documented their own assumptions prior to analysis.
    - Analysis and theme generation were conducted with these assumptions in mind.
- External theme checking with a colleague to assess how meaningfully these represented the data.
- Themes reviewed with a supervisor to check distinctiveness.
- Transcript and findings sent to participants to review
- Evidence of analysis including excerpts of transcripts provided for the reader to aid transparency (see Appendices K & O).
- Participants' professional positioning were considered during analysis in line with Yardley's (2000) assertion that research is "inherently political". This helps to elucidate the social context from which participants speak in relation to power

Table 4. Quality standards performed by researcher

Reflexivity statement

I am a female clinical psychology trainee attending a university course with a critical approach. I have a personal alignment to a social constructionist epistemology, particularly in relationship to understanding and working with mental distress. The bracketing interview (see Table 4) revealed certain assumptions of mine, for example, psychiatrists would find relinquishing power more difficult than other practitioners and training would increase participants' compassion for their clients. Myself and my supervisors all express personal interests in the potential expansion of OD within the UK.

Results

Following data analysis four superordinate themes were constructed based on interpreting the data. These are discussed below with illustrative quotations used. More detailed examples of quotations are provided in Appendix O.

Superordinate themes	Subthemes
A powerful experiential journey	• A “life changing” transformational process • The importance of experiential learning • The dialogical structure: uncontaining versus rich • Learning from the group
Training leads to personal therapeutic change	• Training helps resolve personal and family difficulties • Training leads to personal insights • Becoming more present in-the-moment • Bringing my authentic self: “a journey of integration”
Experiencing deeper and more open relationships	• Becoming more open to others • Feeling deeper connections through “richer relationships” • Understanding the world through a relational lens
Changing relationships with power in working practice	• Becoming more collaborative • Understanding the power of my words now • Finding my voice: challenging power

Table 5. Trainees’ experience of undertaking OD training: superordinate themes and subthemes

Superordinate theme 1: A powerful experiential journey

This theme describes participants’ experience of the process of training and their feelings about the dialogical and experiential teaching methods of the course.

A “life changing” transformational process. Many participants described experiencing a profound and marked change as a result of training itself. A number of participants spontaneously offered terms such as “transformative” when describing their experiences. Notably four of the five members of FG2 used the language of transformation through their shared discussions. Helen, a nurse and family therapist who had already been

working in an OD service for several decades prior to attending the three-year training, said "Maybe I could also start from the feelings and thoughts about this being very transformative" (FG2). The metaphor of a religious conversion was used by two participants in the same FG, which seemed to emphasise the profundity of change to their beliefs, gaining an apparent faith in the method of Open Dialogue. Jerry (psychiatrist, FG3) described remembering feeling "elated" going back to his work after the first teaching block, which Andy (specialist nurse, FG3) followed by commenting he also remembered this time as "almost like I'd had a religious conversion".

Another metaphor three participants used was of a journey. For Ellen (FG1), a peer worker (PW) working part-time in an OD service, the journey described the sense of the ongoing nature of learning and development training had inspired: "there's a sense in which this exploration and this journey is constantly ongoing and constantly developing". The metaphor also appeared to describe participants' sense that passing the course was not the end goal and they had valued the process of development along the way: "I think er, it has been a personal journey for me" (Sophie, a consultant head nurse, FG2).

Individuals' journeys of change were apparently impacted by prior experience; some described how changes in how they perceived the nature of human distress had begun for them prior to the course. Engagement with the Hearing Voices Network was mentioned by participants across different FG initiating such change. After hearing other participants' express experiencing significant changes from training, Fred (FG3), who previously trained in family therapy, a model OD is heavily influenced by, expressed the one divergent view and negative case. For her there was far less distance travelled in terms of new learning: "So I didn't have that sense of the WOW".

. **The importance of experiential learning.** Most participants mentioned the experiential style of the course as particularly beneficial to their learning. There was a sense that having to work through certain exercises, especially those which required them to be vulnerable, led to an appreciation for what was being asked of their clients. Katin (FG2) a peer worker (PW) who also worked in an OD service, described “that’s translated to my practice cos it’s like, I’ve lived that thing that we do with families, how risky it is to be open, and how much we’re asking of them”.

A number of participants also talked about the value of themselves experiencing deep moments of relating or feeling deeply heard by their cohort during exercises or discussions. Ruth, a CP, (FG2), described this motivating her to want to recreate this experience for others in the workplace, both for clients and colleagues:

It’s given me a felt sense of what that place can feel like, and it makes me think as a trainer and a supervisor, how can the people who I’m supporting(…)how can we create a space where they can have the experience of a deeply felt dialogic space?

Some participants commented on the less tangible aspects of experiential learning which were modelled on the course, such as the non-hierarchical structure or “democratised environment” (Aburi, a nurse, FG1) between trainers and trainees, which was felt to help enable everyone have a voice. Trainers modelling acceptability of being vulnerable, by sharing their own personal histories with trainees was also commented on by Llello, a psychiatrist (FG1). Notably, this was mirrored in the content of all three FG, with several participants sharing deeply personal and emotional stories themselves.

The dialogical structure: uncontaining versus rich. Discussions around the dialogical structure of the training prompted debate among participants, and many divergent views were expressed regarding how helpful this was felt to be. Four participants appeared to

find the unstructured nature of the dialogical frame uncontaining and anxiety provoking at points. Kevin (FG1), a nurse who described himself as having little therapeutic training prior to the course, appeared to be sharing a sense of vulnerability evoked by the unstructured learning style. During a conversation with Ellen who held some similar views, he appeared to express some frustration at the trainers, describing them in this quote as irresponsible parents who let students take a big risk with their learning "I mean, it's, it's, like you wouldn't give a child a bunch of razor blades to find out that they're sharp". The extreme nature of this quote emphasises Kevin's powerful emotional response.

Some felt they had not gained some of the core skills needed and expressed anxiety over this, regarding ability to practice the method. These comments most frequently came from practitioners who did not have a therapeutic training background and appeared concerned about not having a grounding in certain methods and theory. After Fred (FG3) described her own "complex" process of "unlearning" as a family therapist, Jerry (FG3), a psychiatrist, commented "You need to know the rules before you break them, and that actually, erm, I need a kind of training in systemic family therapy and the different models, then you can kind of play with it."

Others, conversely, viewed the non-didactic, problem-based learning style positively and found the de-emphasis on drilling specific skills enabled a deeper grasp of the method and more dynamic application: "So, there's something about the depth of the training allowing you to move from a skills, manualised way of implementation, to something, I think that can be much richer" (Ruth, FG2).

Learning from the group. The group itself was cited as providing important opportunities for reflection, which helped individuals better understand themselves or the theory. It seemed many people used the whole-group discussions as a space to practice and

experience the teachings of being dialogical; such as accepting differences of opinion, tolerating difficult feelings and working through internal tensions generated during discussion. “Talking about this, huge group sessions, I’m more, erm, confident being (…)feeling discomfort” (Sophie, FG2).

The group was experienced differently across individuals. For some it was an affirming space where they experienced feeling heard: “Being respected and accepted, so, for, for me this was the, er, most important thing” (Llello, a psychiatrist, FG1). Both Andy and Jerry (FG2) however discussed experienced the large group as challenging at points. Here Andy described attempting to embody a dialogical stance of being fully present to all voices, and finding this level of attention and connection difficult to maintain:

“that’s always the space that I found the most challenging and most disorientating, dizzying(...)with so many different views, feelings (…) and when you try to attend to that, and be part of that, it can feel like, wow” (Andy, FG3).

Superordinate theme 2: Training leads to personal therapeutic change

This theme documents some of the changes which appeared to have therapeutic benefits for individuals. These changes were described as having an impact on participants both personally and professionally.

Training helps resolve personal and family difficulties. Over half of participants shared the training had provided some form of resolution to either personal or family difficulties, which was described as powerful and moving. Many cited the ‘family of origin’ exercises as being the catalyst for these changes. This task consisted of small group discussions of personal histories and letter writing to family members. For some this had shifted long standing family dynamics through facilitating communication and allowed opportunity to hear alternative narratives to their own. As Kevin (FG1), shared “it resolved

something which I had held since I was 17. And I had a, a, memory (…) and it didn't actually happen that way and I only found that through the, the, letters (…) don't know what the word is, powerful". Katin became tearful when talking, demonstrating the emotional impact of this aspect of the training "My mum disclosed some stuff in one of the [homework] exercises that, has changed (.) now I'm crying (…) phew, a big part of my life, and made possible conversations that I never thought were possible".

Two participants (both FG1) suggested a dialogical approach led to them also being more self-compassionate and kinder to themselves. This appeared to relate to a sense of letting go of more rigid patterns of thinking or behaving: "it's possible not to, to fight against these er, things, but to:, to (.) stay with, for a certain period, to (.) let's say, to become friends [with myself]" (Llello, FG1). "I've become less anxious about certain things" (Aburi, FG1).

Training leads to personal insight. Half of participants expressed that, during the training they had gained personal insight or greater self-awareness of their histories or relational patterns and how this might have shaped them. Aburi (FG1) speaks here about how the personal exploration required as part of the 'family of origin' exercise led to a better understanding of himself "I was able to go back in time and revisit my origin and revisit things that happened to me in those, erm, long age [sic] and time and how it has impacted on my journey in life".

Helen (FG2) and Robert (FG3), both of whom already had backgrounds in family work, spoke about how the OD training had given them a new language to understand and describe their own experiences. "Sort of new words and new ideas to describe experience, your own experience" (Robert).

This insight and new knowledge was viewed as critical to informing their practice. Participants described this as then improving their clinical work by being better able to

understand and reflect on their own emotional responses towards their clients. As Ellen (FG1) stated: “And explore how (…) your perception and how your lenses, if you like, have, have built up, that is an absolutely, absolutely critical part of therapy, but also about being a good practitioner as well”. “This is, I did understand that this is my shit and should I bring it here?” (Helen, FG2). Helen described how being more in touch with her personal history helped her recognise and be more in control of unconscious emotional material surfacing in sessions.

Becoming more present in-the-moment. The majority of participants described being more present with others and themselves as a result of the training. For some, this related specifically to changes in their clinical practice, particularly around being more aware of the whole network within a session, rather than focussing on an individual. Kevin (FG1), who had described himself as already working in a network-oriented service prior to training, commented “I’m picking up more (…) I’d also be aware of the two family members (…) my peripheral vision has improved no end”.

Others talked about being a lot more attuned to themselves, including becoming more in touch with their embodied physical responses, as Helen (FG2) noted “So things have been more embodied for me I think”. Paloma (FG2), a psychologist, described how this change allowed her to be less distracted by her own self-critical thoughts and therefore better able to sit with uncertainty within sessions. “I can just be present, and I can be present when it’s not working”.

There were also discussions about the adverse effects of becoming more present in interactions with others; a number of participants described feeling tired and exhausted from the additional effort this took. Jerry, a psychiatrist (FG3) described “All the intense vigilance (…) it was fantastic, it was interesting and it was, erm, but it was very exhausting yeah”.

Bringing my authentic self: *"a journey of integration".* Half of participants discussed how training and practising OD allowed them to integrate parts of themselves they had previously felt required to separate or supress in the workplace. This was described as having a positive impact on participants' wellbeing through feeling more "congruent" (Helen, FG2) with themselves. Helen's contribution was then validated by Sophie who described noticing this change in Helen over training. Participants described feeling like they could now reflect on and express more personal aspects of themselves and their history in their clinical work, either in sessions or supervision:

> not that I think that's necessarily a challenge to boundaries, with professional ways of being, but it seems that you're bringing different qualities, different aspects of you as a person, so (.) maybe using or getting in touch with more of you perhaps (Robert, FG3).

Ruth (FG2) described how this integration came with benefits as well as risks. She had previously kept the personal and professional as separate and that bringing the two together could feel less containing. The risk of sharing her own vulnerabilities seemed to make her fear being less in control: "It has been transformative, um, and challenging as well, because it breaks down, you can have nice little tidy little places". It was notable that Katin, a peer worker, commented she struggled making a distinction between personal and professional as she did not see them as separate, which may reflect that a fundamental activity of peer working involves bringing lived experience into the role.

Superordinate theme 3: Experiencing deeper and more open relationships

The third theme describes changes which occurred in the way in which participants related to others. Some described a fundamental perspective shift towards a relational understanding of the world.

Becoming more open with others. Participants described being more open with others across a range of contexts, including with their families, colleagues and clients, especially about emotional content. Aburi (FG1) spoke movingly about improved communication with his children "Because now we can share things and be able to talk about our emotions and how we feel about things, so it's opening to me, really". Kevin (FG1) talked about positive changes his partner had witnessed in his communication: "She said I never talked enough, er, I don't, don't, I didn't tell her anything and, that's, that's changed."

It was also felt OD training removes the "taboo", thought to exist in mental health settings, around practitioners being open about their own vulnerabilities. "So there are certain things, that I can now, really share, without feeling shame (…) you know" (Aburi, FG1). This appeared to enable greater honesty and ease of connection; Fred (FG3) described feeling comfortable to immediately share more with people who had been through OD training, being likely to share the same philosophy: "there's lots of trainees there that I know have gone through our training and I've never met them before, but I know, you know, it's okay to have those kind of conversations."

Feeling deeper connections through "richer relationships". Participants described how becoming more dialogical led them to having a deeper and richer quality of relationships with others. Several participants appeared emotionally uplifted by these changes: "This is just such a wonderful way, such a rich way of being with (…) with people" (Andy, FG3). Again, this was experienced across a range of contexts including their own families, colleagues and service users. Robert (FG3) describes how this depth of connection led to a shift in client work; where families felt able to share more emotional content in sessions: "It sort of brings you into different territory with people, in the conversations that you're in with families, you know, much more emotional".

For a number of participants, connecting more to clients meant they experienced a sense of sharing a common humanity. Having a deeper connection and understanding also led to caring more for them. Fred (FG3) who had already worked for decades as a family therapist stated: "I think I'm far more respectful (1) of them, cos you know, you genuinely care for them". Again, this was described as coming with risks as well as benefits. Jerry (FG3), a psychiatrist, described how feeling more connected to the distress of others in the work setting left him feeling his defences had been taken away, which left him in a more vulnerable position:

It gets under my skin a bit more, whereas I think I had stronger defences before. So, we had a suicide in the service, and I feel it's hit me more than it would have, in other, maybe more than previous times.

Understanding the world through a relational lens. The third theme to emerge was an apparent fundamental shift in understanding; where social contexts and relationships play a fundamental role in shaping identity. Sophie (FG2) described how this perspective altered her view on the value of dialogue in shaping meaning for others, and this meant feeling more responsibility over what she said: "It makes a difference when people formulate things differently and offer you their view, so it is important to talk, and say what you mean" (Sophie, FG2).

There was also greater emphasis on having a network perspective of mental distress. Jerry, a psychiatrist (FG3) described how the OD approach appeared to more accurately describe the complexity of human experiences than his previous clinical trainings: "Yeah I found it very, um (4) sort of uplifting (…) and kind of true to the reality of the messiness of human beings, so there was the, the experience was very powerful"

Aburi (FG1) also described how the training had altered his understanding of the very nature of "truth" to one of a subjective reality. He felt this had been achieved through the dialogical teaching style of the training. Aburi, apparently wanting to defend the perceived lack of structure or theoretical teaching on the course voiced by others in his FG, stated "Rather than to have a monologue, somebody standing there and telling you this is the absolute truth but we have learnt there are so many truths".

Some participants, notably those who were not currently working in OD services, described experiencing a strong internal tension following this perspective shift. They experienced frustration or even "trauma" over not being able to return to services where this could be applied. Aburi, who had also described family support as important in his cultural upbringing shared:

it is very (…) (sighs) for me, is very (…) traumatic, I will use that word traumatic, because now, whenever I see, for example, I'm given somebody to work with or to look after, I ask (…) where are the family members? (…) that is the first question I ask (Aburi, FG1).

Superordinate theme 4: Changing relationships with power in working practice

The final superordinate theme relates to participants discussions around issues of power, particularly changes they had made to their practice in this regard.

Becoming more collaborative. A significant change described in participants' practice was becoming less directive and working more collaboratively. For some, this had occurred through a process of letting go of control themselves and consequently learning to trust individuals or networks had the resources within themselves. Participants noted positive impacts on themselves; they felt the burden of responsibility was not solely with them but shared among clients and colleagues. A range of practitioners including psychiatrists, nurses and psychologists described this as liberating and freeing: "Yeah, the over responsibility, I

think I’ve had a bit too much of that, I think that’s perhaps also why I feel like flying” (Paloma, FG2). Both psychiatrists, across two separate groups, noted clients responded positively to their change in practice when they practiced collaborative working. As a consequence both noticed how clients appeared to gain more agency themselves: “But when I started to shift from this position and to say, also sometimes I, I, I’m confused, I don’t know if this should be better than that, er this produced more changes” (Llello, FG1).

A few participants specifically mentioned not bringing an agenda was the biggest change to their practice and this meant they could be more present and dialogical within sessions. Aburi (FG1), a nurse, talked about the process of having to tolerate uncertainty to be able to achieve this change, and recognising that previously more directive practice had been a means of alleviating his own anxiety:

> And often times in the medical model we carry our anxiety across to the person which is sort of um, um, erm, infusing the anxiety into the other but if I hold my anxiety and tolerate the anxiety things might not get worse, you know, we can muddle through.

Understanding the power of my words now. Linked to the above theme, participants expressed a new understanding of the power of their words to control or influence their clients. Notably, this was again discussed across a range of roles with varying degrees of perceived power within current mental health services. Llello, a psychiatrist (FG1) describes becoming more mindful of both his motivations to share and the impact sharing would have on their clients to influence or coerce: “I, hope I’m, I’m more aware that er (.) bringing something from my personal experience could be an attempt to, (2) say to the othe:r,, follow my example (.) or sort of hidden suggestion”. Katin, a PW (FG1) also described becoming more self-reflective in regard to what she shared and thought more

deeply about the impact on the client: "Whether I choose to share or not, and try to notice the impact of my sharing as much as possible, if I need to sshh!".

For some, being quieter came as a result of becoming better listeners and understanding the importance of allowing others to speak. Following a thoughtful observation on Helen's process of change during the course, Sophie (FG2), a consultant and head nurse noted: "so I'm more, erm, humble in a way and I think I'm a better listener".

Finding my voice: challenging power. The final theme described how some participants appeared to grow in confidence around being able to assert themselves as a result of training. For some this meant feeling more motivated and better able to question poor practice within a hierarchy. Both a nurse and PW gave examples of times, since training, where they had challenged particular practices and felt that in so doing they had averted significant harm happening to their clients:

Now I am able to (.) challenge certain things really, especially in the area of medication(…) I went back to the doctor and I said to her, there's no way am I going to stick this needle into this patient (Aburi, FG1).

Some referred specifically to the importance of learning about Bakhtin's concept of a "polyphony of voices", where all voices are viewed as having equal validity and narrative weight. This had enabled them to see their own voices as valuable, especially in relation to others with more assumed power. This meant they had become more confident to contribute to work discussions: "I think that my thoughts and words count now (…) for myself" (Helen, FG2).

Ellen, a PW, felt the training had impacted on her role in the organisation, enabling her to influence change at a broader level than before. This appeared to come from an internal shift in the way she viewed her own value and contributions: "I suppose the, like, training

then for me has helped to provide a framework to do that(…) I feel as though I've got more, my sphere of influence is much broader (1) now, erm, than before" (Ellen, FG1).

Discussion

The aim of this study was to explore the experiences and subjective impact on trainees undertaking a three-year OD training course. Participants spoke both about the process of undergoing training, as well as the changes experienced as a result. The findings suggest participants, drawn from a broad range of mental health practitioners, observed marked changes in themselves and their practice, with some describing the process as transformational.

Most participants, including those not currently working in OD services, described changes to their professional practices as a result of the training, particularly in regard to power. Many gave examples of effective collaborative working, sharing power with clients and colleagues and challenging poor practice within a professional hierarchy. Notably, participants described such changes as liberating. This may be explained by practitioners' apparent epistemological shifts. As Strong (2011) suggests a dialogical approach in therapy, where practitioners uphold a social constructionist perspective, can help lead to "flattened-hierarchies" (p.1), as meaning and language are seen as negotiated with others. Evidence from this study appears to contrast positively with predictions made by NHS staff and service users that one of the key challenges to implementing OD in the UK would be culture shifts around sharing power and expertise for practitioners (Razzaque & Wood, 2015). The current study can however provide no objective measure of change in working practices. The self-selecting nature of this cohort, who were likely open to the approach, should also be noted.

The study also offers some novel insight into which aspects of training led to the profound changes described. Experiential exercises were most frequently noted as having a

deep impact on learning. Performing ‘family of origin’ letter writing exercises were described as having a therapeutic impact and led to resolutions to trainees’ own personal and family difficulties, as well as helping trainees to understand the emotional demands and vulnerability being asked of their clients. According to Bion (1962), transformations of thought require learning by experience. Emotional uncertainty of sensory experience is required to be processed and turned into a conscious thought, otherwise it can continue to be denied and defended against (Bion, 1961). It could be hypothesised such experiential learning helped trainees gain trust in the process which could help practitioners “tolerate uncertainty” within sessions with clients, one of the seven OD key principles (Olson *et al*., 2014). In line with Bion (1961), Mason (2015) argues that practitioners enduring “safe uncertainty” can lead to more empowering and less authoritative therapeutic practices. This finding may be critical in light of the current NHS research trial using a condensed one-year training as part of their study, with a greater emphasis on manualised skills building. This may affect how the approach is delivered and subsequent clinical outcomes for clients.

Critically perhaps, the role of the group itself in training was also emphasised. Such group-based dialogical learning also more authentically reflects an individual’s social reality and the pluralities of relationships, which helps facilitate both experiential learning and healing through an emphasis on non-linear causality (Schmid, 2001).

These findings also contribute to the theoretical literature on transformational learning. Many participants appeared to value the problem-posing, non-didactic process of learning, which included a “democratised environment”; where trainers modelled flattened hierarchies. Some commented on how dialogical reflective teaching methods led to a richer understanding of OD and an ability to dynamically apply their learning in clinical work. The teaching style employed appears to mirror key features of what Freire & Macedo (1995) describe as critical pedagogy; which involves engaging students in the social construction of

knowledge where learners help shape their own learning experiences. Freire (1970) argued this form of education can lead learners to develop a "critical consciousness" which questions positions of power and can lead to social change. This appears to have been mirrored in the findings with many changes in working practices described by participants, reflecting altered relationships with power. Arguably such individual changes may still fail to translate to system level change, especially within hierarchical systems of the NHS which are reinforced by structures of professional responsibility and pay. Indeed, one participant described the "trauma" of not being able to integrate their new perspective when returning to work in mainstream services.

Trainees also expressed challenges however, in line with Garvett's (2004) findings, in that some participants experienced the dialogical, problem-based learning as deeply anxiety-provoking. Some were left questioning if they had obtained the necessary skills to practice OD, even those who also described changes in their work. Notably, this anxiety was more likely to be voiced by participants without a core therapeutic training background. This may reflect the need to deploy 'differentiation' teaching methods across practitioners with different prior experience, to bridge the gap for staff less experienced in psychotherapeutic work. Arguably, this may also mirror Seikkula's (2011) observation that many practitioners initially struggle to embody dialogism as a "way of life" and continue to see themselves as "interventionists".

Another novel finding was that participants experienced deeper connections with service users through their training. One participant believed this led to families being able to share more emotional content in clinical meetings. Rogers (1977), suggested authenticity in the therapist inspires authenticity in the client, which in turn help breaks through defensiveness. This deeper connection described therefore may link to and be facilitated by

another finding, that participants described training as enabling them to bring their a more integrated, authentic self into practice.

Strengths and Limitations

One strength was the ability to represent a diversity of views across professional roles and backgrounds. During planning, concern was raised that this mix of practitioners may have led to power imbalances within FG. This could have affected individuals' ability to speak openly, although did not appear to have occurred.

Another strength was the, relatively novel, use of Fg data in an IPA study. Arguably this methodology upholds the dialogical stance of OD. As Tomkins and Eatough (2010) note, paying attention to how participants' realities are constructed, through their real-time dialogue with one another, provides another dimension of interpretation and can therefore enrich understanding of the data.

A limitation was the lack of longitudinal data capturing changes participants perceived themselves to have made. It is not possible to know whether the shifts in understanding and practice will be sustained over time, considered to be a key feature of TL (Taylor, 1998). Further research is required to understand whether the changes described impacted service users or led to improved outcomes. Another limitation is the self-selecting nature of the cohort of trainees interviewed. The majority of trainees had been strongly motivated to enter training and many described being aligned with OD values prior to attending training.

In addition, almost half the participants either working outside the NHS or UK, which limits what implications this study has for understanding the adoption of OD into the UK mental healthcare system. For example, participants who come from private healthcare

systems may already work in a more needs-adapted way, which may require less transformation in their professional practice.

The sample size and qualitative design of the study mean results are not generalisable. FG participants were also self-selecting and those from the cohort who chose not to participate may have held less positive views. According to Smith (2017) however, qualitative research can offer analytical generalisability, for example, where research can be applied to models or theories to help enhance understanding in that area.

Implications for clinical psychology

Some participants spoke about the risks involved of feeling more connected to others' distress. This was described as leading to the breaking down of the protective defence of emotional distancing from clients. This strategy can be a common coping method in healthcare settings, as discussed in the classic paper by Menzies-Lyth (1960), detailing the institutional distancing from clients' distress by nurses on hospital wards. Deeper connections may also risk "compassion fatigue" (Figley, 1995) thereby reducing workers' capacity to be interested in, or bear the suffering of others (Figley, 2002), arguably a critical therapeutic task of OD practice. A critical role for CPs within OD teams would be to offer evidence-based interventions which support resilience and reduce or prevent burnout, such as reflective practice (Paget, 2001).

Evidence from this study emphasises the critical role of experiential learning in deepening understanding of the approach being taught and helping practitioners to understand the therapeutic process which clients undergo. A broad range of therapeutic training courses, including the CP Doctorate, could consider introducing a greater focus on dialogically-based teaching methods and experiential learning.

An important caution also raised by the study however is how this style of education can be experienced as uncontaining and provoke anxiety among learners. Another role for CPs could be around providing consultation regarding how best to support the emotional needs of trainees if OD courses are rolled out more widely.

Finally, this study offers further support for the OD method through participants' descriptions of positive changes in clinical practice. This may provide a partial challenge to CPs' emphasis on delivering diagnosis specific interventions and one-to-one therapies and encourage the profession to bring clients' social networks more into the process of their recovery.

Future research

One limitation of the study was the inability to demonstrate whether changes described by participants were definitively a result of training. Dialogical analysis of similar FG data collected before and after training could help demonstrate whether the "dialogical shift" described by participants contributes to genuine changes in communication patterns and thinking; such as turn taking, present moment responding and non-diagnostic language.

The research also suggested dialogical teaching methods can be anxiety provoking for some practitioners, particularly those without a background therapy. Further research is needed in order to understand how courses may adapt to suit trainees diverse learning needs.

Conclusion

In conclusion, this study strongly suggests the transformational potential of OD training. Novel findings suggest participants embraced culture shifts around power sharing in their working practices and experienced deeper connection with clients as a result of training. Dialogical teaching methods appeared to help foster TL and lead participants to alter their practice in relation to power dynamics. The study is limited by the cohort of trainees having

voluntarily attended a privately funded course and may not represent potential challenges in a wider NHS workforce. CPs may be well placed to support with staff resilience in OD teams and could consider a greater inclusion of social networks in their own clinical work.

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Section C: Appendices of Supporting Material

Appendix A: CASP (2018) qualitative checklist

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Appendix B: Quality appraisal of selected qualitative studies using CASP (2018) checklist

	S1	S2	S3	S4	S6	S7	S8	S9	S10
Section A: Are the results valid?									
1. Was there a clear statement of the aims of the research?	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)
2. Is a qualitative methodology appropriate?	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)
3. Was the research design appropriate to address the aims of the research?	Y (2)	Y (2)	N/C (1)	N/C (1)	N/C (1)	N/C (1)	Y (2)	Y (2)	Y (2)
4. Was the recruitment strategy appropriate to the aims of the research?	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	N (0)	N/C (1)	Y (2)	Y (2)
5. Was the data collected in a way that addressed the research issue?	N/C (1)	N (0)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)	Y (2)
6. Has the relationship between researcher and participants been adequately considered?	N (0)	Y (2)	Y (2)	Y (2)	N/C (1)	N/C (1)	N/C (1)	N/C (1)	N (0)
Section B: What are the results?									
7. Have ethical issues been taken into consideration?	N/C (1)	N/C (1)	N/C (1)	N/C (1)	N (0)	Y (2)	Y (2)	Y (2)	N (0)
8. Was the data analysis sufficiently rigorous?	N (0)	Y (2)	N (0)	Y (2)	N/C (1)	N/C (1)	N/C (1)	Y (2)	N/C (1)
9. Is there a clear statement of findings?	Y (2)	N/C (1)	Y (2)	Y (2)	N/C (1)	Y (2)	Y (2)	Y (2)	N (0)
Section C: Will the results help locally?									
9. How valuable is the research?	Y (2)	Y (2)	Y (2)	N/C (1)	N/C (1)	Y (2)	Y (2)	Y (2)	Y (2)
Total	**14**	**16**	**16**	**17**	**13**	**15**	**17**	**19**	**15**

Y= Yes, N= No, N/C= Not clear

Papers were also rated by another trainee and disagreements explored until consensus reached.

Appendix C: National Institute for Clinical Excellence (NICE, 2012) Quality appraisal checklist- quantitative studies reporting correlations and associations

Study identification: Include full citation details		
Study design: • Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? • Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?	++ + − NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? • Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? • Was the eligible population representative of the source? Were important groups underrepresented?	++ + − NR NA	Comments:

1.3 Do the selected participants or areas represent the eligible population or area? • Was the method of selection of participants from the eligible population well described? • What % of selected individuals or clusters agreed to participate? Were there any sources of bias? • Were the inclusion or exclusion criteria explicit and appropriate?	++ + − NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. How was selection bias minimised? • How was selection bias minimised?	++ + − NR NA	Comments:
2.2 Was the selection of explanatory variables based on a sound theoretical basis? • How sound was the theoretical basis for selecting the explanatory variables?	++ + − NR NA	Comments:
2.3 Was the contamination acceptably low? • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias?	++ + − NR	Comments:

	NA	
2.4 How well were likely confounding factors identified and controlled? • Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias?	++ + − NR NA	Comments:
2.5 Is the setting applicable to the UK? • Did the setting differ significantly from the UK?	++ + − NR NA	Comments:
Section 3: Outcomes		
3.1 Were the outcome measures and procedures reliable? • Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking −)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? • Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	++ + − NR NA	Comments:
3.2 Were the outcome measurements complete?	++ +	Comments:

• Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?	– NR NA	
3.3 Were all the important outcomes assessed? • Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + – NR NA	Comments:
3.4 Was there a similar follow-up time in exposure and comparison groups? • If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. • Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + – NR NA	Comments:
3.5 Was follow-up time meaningful? • Was follow-up long enough to assess long-term benefits and harms? • Was it too long, e.g. participants lost to follow-up?	++ + – NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?	++	Comments:

• A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. • Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	+ – NR NA	
4.2 Were multiple explanatory variables considered in the analyses? • Were there sufficient explanatory variables considered in the analysis?	++ + – NR NA	Comments:
4.3 Were the analytical methods appropriate? • Were important differences in follow-up time and likely confounders adjusted for?	++ + – NR NA	Comments:
4.6 Was the precision of association given or calculable? Is association meaningful? • Were confidence intervals or p values for effect estimates given or possible to calculate? • Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + – NR NA	Comments:
Section 5: Summary		

5.1 Are the study results internally valid (i.e. unbiased)? • How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? • Were there significant flaws in the study design?	++ + −	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? • Are there sufficient details given about the study to determine if the findings are generalisable to the source population? • Consider: participants, interventions and comparisons, outcomes, resource and policy implications.		

Appendix D: Ethical Approval

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Appendix E: Open Dialogue three-year training programme course description

Taken from course website: http://open-dialogue.net/training/full/

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Appendix F: Participant Information Sheet

Participant Information Sheet

Understanding the experiences of practitioners who have undertaken three-year Open Dialogue training.

Invitation to take part

Hello, I would like to invite you to take part in a research study as part of my clinical psychology doctorate thesis at Canterbury Christ Church University, Salomons campus. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of the study?

The purpose of the research study is to explore your experience of attending the three-year Open Dialogue training; what might have changed as a result of training and how this might have affected your practice, you as a person and your views towards service users. This work is being conducted to better understand how the Open Dialogue approach might be integrated into the UK mental health system.

Why have I been invited?

You have been invited because you have attended the three-year training Open Dialogue training. We want to explore experiences of the training from the perspectives of a number of different professional roles.

What will happen to me if I take part?

You will be asked to attend a focus group with some of your fellow current trainees. This will be at the same site as the Open Dialogue training. Each focus group discussion will last up to 1.5 hours long but please allow approximately two hours for the task in total. During these focus groups, I will ask you to consider and discuss a number of questions together as a group. The sessions will be recorded using a password protected audio recorder and you will be asked to choose a pseudonym for yourself for confidentiality.

Once initial analysis of the data has been performed you will be asked to comment on how accurate you feel this represents the views you shared at the time, however this task is entirely voluntary.

What will I get from taking part?

I will provide refreshments for all the focus groups to thank you for agreeing to participate in the study. Your time will also contribute to expanding understanding of role of Open Dialogue training in professional practice. You can also claim up to £10

travel expenses if you need to travel to the site. You will also have contributed to providing a better understanding of practitioners' experiences of Open Dialogue training, which may support the programme's integration into, and improvement of, UK mental health services.

What will happen if I don't want to carry on with the study?

You can withdraw from the group or the research study at any point whilst it is being conducted, and your data will be destroyed.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. All participants will be given a unique data number used to identify their data. On one database your general demographic data including age, gender, ethnicity and social background will be collected. On another database, your name and contact details will be stored to arrange the interviews for the research. Only myself and supervisors Dr Jo Allen, Anne Cooke and Dr. Sue Holltum will have access to your personal data, which will be destroyed once the final follow-up interviews have been conducted. Pseudonyms will be used when writing up the results for publication.

What will happen to the results of the research study?

You will not be identified in any report or presentation of the results. You will be provided with a written summary of the results if you would like. The research also will be written up and submitted as part of a doctoral course in Clinical Psychology with an aim to publish the results in a peer-reviewed journal.

Who is organising and funding the research?

The research is organised and funded by Canterbury Christ Church University.

Who has reviewed the study?

This research has been looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by Salomons Centre for Applied Psychology Ethics Panel (within Canterbury Christ Church University).

Further information and contact details

If you would like to speak to me and find out more about the study or have questions about it answered, please feel free to email me, Ali Wates on: a.wates661@ @canterbury.ac.uk

Appendix G: Consent Form

Consent form

Participant name:

Participant Identification Number (leave blank):

Title of Project: Understanding the experiences of practitioners who have undertaken three-year Open Dialogue training.

Name of Researcher: Ali Wates

Please tick in box

1. I confirm that I have read and understand the information sheet dated _________ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason, without my legal rights or assessment by the course being affected. ☐
3. I consent to the focus group being video and audio recorded. ☐
4. I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐
5. I agree to respect the confidentiality of my fellow focus group participants ☐
6. I agree to take part in the above study. ☐

I wish to have a copy of the transcript of the focus group to check its accuracy (you may change your mind about this at any time) **Yes/No**

I wish to take part in checking findings from the research and offering my comments on the work (you may change your mind about this at any time) **Yes/ No**

Name of Participant________________________________ Date________________

Signature ___________________

Name of Person taking consent ______________________Date_____________

Signature ____________________

Appendix H: Focus group schedule

Focus group schedule

Preamble "The main focus of today's group is to explore your personal experiences of the Open Dialogue training.

I want to know about you and your personal experiences and what they mean for you, so I may prompt you to talk more about this or in this way at times. There are no right or wrong answers.

It's important that for the purpose of this study you speak from your own experiences, don't feel you need to represent the voice of other people.

Please feel able to take your time to think before responding if needed.

I have 6 questions, each with some follow ups, so at times may need to move us along to the next question.

I will ask you some questions and then I would like you to discuss them together as a group, rather than responding back to me. I will say very little myself.

That's what we will be spending most of our time talking about together today.''

ICE BREAKER- Please could you go round and introduce yourself for the recording. When I write this up I am also give you all pseudonyms so please say your full real name, job title and a pseudonym you would like for me to refer to you as, this should not be a name that other people could identify you by.

Any questions before we start?

Main section

''OK, just to start, I would like to ask you a few general questions, to learn a bit about you. We won't spend too much time on this. It would be helpful if everyone could say a bit."

1. What made you attend the training? (approx. 10 mins)
   Follow ups
   a. What were your motivations to attend?
   b. How did you feel about doing the training?
   c. What made you want to talk about your experiences?

2. Tell me a little about your current job role and what (if any) training in mental health you received before the Open Dialogue training? (10 minutes)
   Follow ups
   a. What model(s) were you trained in?

3. What has been your experience of the Open Dialogue training? (approx. 20 mins)
   Follow ups
   a. What has this meant to you?
   b. Has anything stood out when you think back over the training?
      i. What has this meant to you?
      ii. Why were they important to you?

4. How (if at all) do you feel the training has affected the way you approach your day to day working practice? (approx. 20 mins)
   Follow ups
   a. Has anything stood out when you think back over the training that effected this?
      i. What has this meant to you?
   a. Have you experienced any difficulty with integrating this with your previous way of working?
      i. How did this affect you?
   b. Have there been any changes to the way you view yourself as a practitioner as result of the training?

5. Broadening this out, have there been any changes to the way you view yourself as a person as result of the training? (approx. 20 mins)
   Follow ups
   c. How do you feel about this?
   d. What has this meant for you?
   e. Has anything stood out when you think back over the training that effected this?

6. OD invites practitioners to bring their own experiences into sessions- how has this felt for you? (approx. 20 mins)
   Follow ups
   a. Has this increased the amount you disclose in your work?
      i. How has this felt?
   b. Has the training impacted on your perception of people who struggle with mental ill-health who are accessing the services you work in?
      i. In what way?
      ii. Has this affected your practice and in what way?
   c. Has the training impacted on how you feel about or understand your own experiences of mental ill-health or struggles in life before coming on the course?

***If time**

How are you feeling about the course coming to an end?

Debrief

“Thank you. The group is now coming to an end. I would just like to check in with you how you have found the group. How did it feel to do the group?

Was there anything you particularly enjoyed or found useful?

Do you have any questions about the focus group or the study? Is there anything you would like to ask me? I am very grateful for the time and attention you have given to this process.

I will be around now while packing up, if there was anything that you found particularly difficult to talk about, please let me know. If you feel you need support please come and speak to me, I am also providing some information about services you can access if you would like to speak to someone independent for support. You also have my contact details if anything arises after leaving today that you would like to discuss further. ‘’

Appendix I: Demographics questions

DEMOGRAPHICS FORM

Participant ID (leave blank):

1. Sex: Are you?

- [ ] Male
- [ ] Female
- [ ] Other
- [ ] Rather not say

2. Gender: I identify my gender as…

- [ ] Male
- [ ] Female
- [ ] Trans male
- [ ] Trans female
- [ ] Non-binary
- [ ] Prefer to self-describe as ____
- [ ] Rather not say

3. Your Ethnicity

White:

- [ ] White British
- [ ] White Irish
- [ ] Any other White Background (please specify)________________________

Black or Black British:

- [ ] African
- [ ] Caribbean
- [ ] Other Black background (please specify) ___________________________

Asian or Asian British:

- [ ] Indian
- [ ] Pakistani
- [ ] Bangladeshi
- [ ] Any other Asian Background (please specify) ______________________

Chinese or Other Ethnic Group:

- [ ] Chinese
- [ ] Any other Ethnic Group (please specify) ______________________

Mixed Ethnic Background:

- [ ] White and Black Caribbean
- [ ] White and Black African
- [ ] White and Asian
- [ ] Gypsy and Traveller
- [ ] Any other mixed background (please specify) ____________________
- [ ] Rather not say

4. Age: How old are you? (please write age in years in box below)

- [ ]
- [ ] Rather not say

5. Marital status: are you?

- [ ] Civil partnership
- [ ] Cohabiting
- [ ] Single
- [ ] Divorced
- [ ] Separated
- [ ] Married
- [ ] Widowed

☐ Rather not say

6. Employment status: Are you?

☐ Employee: part time
☐ Employee: full time
☐ Self-employed: part time
☐ Self-employed: full time
☐ Full-time student
☐ Part-time student
☐ Unemployed
☐ Voluntary work
☐ Rather not say
☐ Other (please specify) ____

7. Please state your job title(s)

____

____

8. How long have you worked in the above job role(s)? (in years and months)

☐

9. NHS: do you currently work for the NHS, either full or part-time?

☐ Yes
☐ No

10. *If no*, where do you work?

- [ ] Within the United Kingdom
- [ ] Outside the United Kingdom

11. Have you worked for the NHS in the past 5 years?

- [ ] Yes
- [ ] No

12. Are you currently working in an Open Dialogue service?

- [ ] Yes
- [ ] No
- [ ] Rather not say

13. *If yes*, do you?

- [ ] Work full-time in an Open Dialogue service
- [ ] Work part-time in an Open Dialogue service
- [ ] Rather not say

14. Do you consider yourself to have lived experienced mental health ill-health?

- [ ] Yes
- [ ] No
- [ ] Rather not say

15. Have you ever accessed mental health services?

- [ ] Yes

- [ ] No
- [ ] Rather not say

16. <u>If yes</u>, were these mental health services?

- [ ] NHS
- [ ] Private
- [ ] Both
- [ ] Other
- [ ] Rather not say

Thank you for completing

Appendix J: Details of further support provided to participants

Further support

If something that has been discussed today has caused you distress or brought up difficult emotions please feel welcome to speak to me at the end of the session. You can also contact me to discuss any issues which may have arisen as a result of taking part in the research, my email address is a.wates661@canterbury.ac.uk

If you would prefer to speak to someone independent here are the contact details for a national services who offer support.

Service: Samaritans, who are a UK charity offering support to people who are experiencing emotional difficulties or are feeling suicidal

Telephone contact: 116 123

Availability: Open 24 hours, every day of the year

Service: SANE, who are a leading UK mental health charity improving quality of life for anyone affected by mental ill-health - including family, friends and carers.

Telephone contact: 0300 304 7000

Availability: Open every day of the year from 4:30pm to 10:30pm

Appendix K: Sample transcript

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Appendix L: Initial themes generated for presentation at OD conference

Themes

WORK IN PROGRESS

- **Power (speaking more and less)**
  - Challenging hierarchy
- **Relieving tensions**
  - Personal and professional- aligning with values
  - Less pressure of individual practitioners/service responsibility
- **Experiential learning**
  - What is being asked of families
  - Being heard experienced as affirming
- **Healing/ therapeutic**
- **Content vs process**
- **Greater relational depth-**
  - With service users and colleagues and fellow trainees

Appendix M: Initial codes and code development

	Initial code
1	Deeper connections
2	Caring more
3	Relating differently
4	Family resolution
5	Personal resolution
6	Self-awareness
7	More open (variety of contexts)
8	Speaking less
9	More present
11	Authentic self
12	Integration of split self
13	Finding voice
14	Experiential learning
15	Change "just happening"
16	Reflective space
17	Dialogical structure of learning
18	Group process
19	Valuing the network
20	Transformational
21	Relational shift
22	Believing in network approach
23	New way of understanding distress (own and others')

24	Less directive
25	Tolerating uncertainty
26	Flattening hierarchy
27	New understanding of power
28	Positioning in physical space
29	Tension of returning to services
30	Trainers modelling vulnerability
31	Being heard
32	Deep listening
33	Being vulnerable
34	Rediscovering values
35	Letting go of agendas
36	Flexibility
37	Family as key to recovery
38	Epistemological shift
39	Collaboration
40	Shared responsibility
41	My words count
42	Sharing more
43	Metaphor of journey
44	Religious conversion
45	Insight
46	Embodied response

Superordinate themes	Subthemes	Initial themes						
A powerful experiential journey	· A “life changing” transformational process	Transformational	Journey	Religious conversion				
	· The importance of experiential learning	Experiential learning	Change "just happening"	Being heard	Being vulnerable			
	· The dialogical structure: uncontaining versus rich	Dialogical structure of learning	Flattening hierarchy	Deep listening				
	· Learning from the group	Reflective space	Group process	Valuing the network				
Training leads to personal therapeutic change	· Training helps resolve personal and family difficulties	Family resolution	Personal resolution					
	· Training leads to personal insights	Self-awareness	Insight					
	· Becoming more present in-the-moment	More present	Embodied responses					
	· Bringing my authentic self: “a journey of integration”	Authentic self	Integration of split self	Rediscoveri ng values				
Experiencing deeper and more open relationships	· Becoming more open to others	More open (variety of contexts)	Sharing more					
	· Feeling deeper connections through “richer relationships”	Deeper connections	Caring more					
	· Understanding the world through a relational lens	Relating differently	Relational shift	Believing in network approach	New way of understan ding distress (own and others’)	Tension of returning to services	Family as key to recovery	Epistemological shift
Changing relationships with power in working practice	· Becoming more collaborative	Less directive	Tolerating uncertainty	Letting go of agendas	Flexibility	Collaboration	Shared responsibil ity	
	· Understanding the power of my words now	Speaking less	New understanding of power	Positioning in physical space				
	· Finding my voice: challenging power	Finding voice	Words count					

Appendix N: Mapping individual contributions onto FG level themes

	ABURI	ELLEN	KEVIN	LELLO	KATIN	PALOMA	SOPHIE	RUTH	HELEN	JERRY	FRED	ROBERT	ANDY
PROCESS													
Experiential journey	X			X	X	X		X	X			X	X
Dialogical structure	X	X	X		X			X		X		X	X
Group				X	X	X	X	X	X	X	X		X
Transformational process		X		X	X	X	X	X	X	X	X (-ve)		X
POWER													
Power of words	X			X	X		X				X	X	X
More collaborative	X	X	X	X	X	X	X	X		X	X	X	X
Finding a voice	X	X	X	X					X		X		
RELATIONAL CHANGES													
More open	X		X		X		X	X			X		
Deeper connections	X	X			X	X		X		X	X		X
Relational lens	X	X	X (-ve)		X	X	X	X		X	X (-ve)	X	X
THERAPUTIC INFLUENCE													
Personal/ family resolutions	X	X	X	X	X	X	X			X			
Personal insights	X	X		X	X (&-ve)	X		X	X			X	
More present		X	X	X		X				X		X	X
Integration	X		X				X	X	X	X		X	

Appendix O: Sample of participant quotes for each theme

A "life changing" transformational process

maybe I could also start from the feelings and thoughts about this being very transformative (2) (Helen, FG2)

I think er, it has been a personal journey for me (Sophie, FG2)

Yeah, I was thinking (2) the journey is also what I'd use for me to say it has been a, a (2) wonderful journey (Paloma, FG2)

well it's not a bad question for me to jump off because I was going to call it life changing (Ruth, FG2)

But anyway, um, it's been really changing, life changing (Ruth, FG2)

there's a few bits that I found really transformative, (Katin, FG2)

The other transformation for me has been the family of origin (Katin, FG2)

it's probably been one of the, the, certainly, most enlightening and true gift (Paloma, FG2)

I remember that Sunday before we went back on the Monday, the very first block in April, April wasn't it? And I remember feeling really excited ((smiling)), you know, almost like I'd had a religious conversion (Andy, FG3)

so there's a sense in which this exploration and this journey is constantly ongoing and constantly developing (Ellen, FG1)

if I was thinking about what has been transformative, it has been (.) the relational depth of the connections, which have been incredibly significant. (Ruth, FG2)

NEGATIVE CASE- it's been mixed for me I think, e:rm, because I think as a family therapist coming in, the family therapy training was a real lightbulb moment for me, it was a life changer, so I'd already had that experience I think, which, possibly others may have had here, but, so I didn't have that sense of the WOW (.) erm, but there's been moments where its… so I've had moments where I've felt I've done this already but other moments where its felt really rich.(Fred, FG3)

The importance of experiential learning

that's translated to my practice cos it's like I've lived that thing that we do with families, how risky it is to be open, and how much we're asking of them and I think if I hadn't had gone through that I wouldn't have realised what we're asking (Katin, FG2)

its, given me a felt sense of what that place can feel like, and it makes me think as a trainer and a supervisor, how can the people who I'm supporting developing their practice how can we create a space where they can have the experience of a deeply felt dialogic space? And I

also think that it has really changed my practice in that, (2)(sigh) there's no going back (Ruth, FG2)

In terms, very similar to what people have said but for me there have been specific skills that I've picked up, and they've not been taught, which is interesting, so, one of them, is around being more comfortable reflecting (Katin, FG2)

well I think it's what you were talking about ((gestures towards Ruth)) to be seen and heard and acknowledged (Helen, FG2)

and I always have this thing 'just trust the process, just stay with it' and something does happen, when you stay with it, and people feel heard and people feel really listened to, even when things have got quite heated, there's a real charge you know, in the room, I've never had a session that's ended that way, I can say that, never had them end that way, just staying with it, yeah, and it was seeing that, that (2) done, I think I needed to see it to believe it, does that make sense? (Andy, FG3)

the family of origin thing, but the depth and sharing (Paloma, FG2)

here I remember Franco (2) with tears in his eyes, remembering a college of him who died (.) and this was absolutely the reason, the main reason, then when we had to choose in which group, in which family of origin group should I to come, I say with him

= Aburi: =yup=

Llello: =because he is not scary [sic] of showing his emotions (Llello, FG1)

that experience of being listened to, and what it is like to be in this space, where you are just heard ((laughs)) and you share something and you are hearing it yourself for the first time, and it is a different thing to individual psychotherapy (Ruth, FG2)

family of origin tasks that we had to do, you know, it seemed kind of something, seemed straight forward about what we were being asked to do apparently, but the actual process you know, of, of doing it, being with people, being listened to, and the, the, the pace of it, it was just such a special kind of experience, I find it hard to put my finger on what, what exactly it was (Robert, FG1)

so, we, I, I think, we, I introduce it to this sort of less hierarchical dialogue environment (Aburi, FG1)

it was like a parallel process going on between, how we might be when we're working in that work, and how we worked with by the trainers, it felt very, use the word affirming (Andy, FG3)

The dialogical structure: uncontaining versus rich

but with regards what you said about the structure, I feel as though there should be more structure, er, I felt that we've come to this course expecting to be taught something and I think a lot of the time it's been us finding our own way

Ellen: yes

Kevin: without any direct monologue, and I know it's a, a, dialogical approach, however I think in an education system you need to be taught (Kevin, FG1)

but just in response to what you were saying , I feel, that one thing we have lacked, compared to my experiences on my foundation training, is a focus on developing our skill (Ellen, FG1)

on the other hand, this is about, this particular course is more about practice, rather than theoretical knowledge giving. If I understand it in that way, because I think earlier on, they were talking about this is about doing, and being in the moment, and not about regurgitating theories and going back to that particular academic theory line (Aburi, FG1)

in terms of structure and the erm, theoretical imbalance, it just struck me now that it was purposively coined that way to remove the monologue (Aburi, FG1)

I think there's something about how, some of the exercises that were done to, as you say, were very done in a very, you know, we need to figure stuff out for ourselves and we navigate through this for ourselves. Erm, I suppose for me, there's that, that, has played a really important part (Ellen, FG1)

but for three years you think, aaah, I'm losing a lot of time here (Ellen, FG1)

very English, you know, skills that we need to learn, and that kind of oh maybe we'll get the next module and then… but that's for me translating between a kind of a very structured course and this idea that I need to learn specific things in order to be able to do this, to a process course where actually where actually all of these conversations are the learning, and the role plays and the family of origin (Katin, FG2)

when I was doing this thesis, I came across this sentence that "dialogism is created in dialogues" Others: mmm Helen: And I really liked that, and I think that that's something that has happened here (Helen, FG2)

well (1) you sort of go with it if you like and sort of tolerate the uncertainty and work within the structures that you have (Ellen, FG2)

Learning from the group

because the first thing that came to my mind wasn't the training it was the connections I've made ...erm, with so many different people and that I carry bits of you (Katin, FG2)

through, uh, hard training, hard processes, er, in relationship with you and not just hard, I mean lovely, hard, difficult, good (Sophie, FG2)

absolutely again, that it's the, the, people, actually (Paloma, FG2)

And when I'm not here I look forward to this space as a space in which, I can be (1), aah, a bit real, but also I can be excited and I can have these very real, very rich conversations about these (1) niche ((laughs)) ideas (Ruth, FG2)

I've done shit loads of therapy so I was like, do I really need to go into this? After individual therapy. But there's something about doing it in a group (Katin, FG2)

which has been really, really meaningful, but also the conversations in the big group (Helen, FG2)

: yeah I was thinking of course the, the big groups have played a big role (Paloma, FG2)

probably the times where I've not agreed with people on the course and have been really curious about whether I'm interested in actually having the conversation and engaging and inviting something that will be useful, or whether I'm not and sometimes I have and sometimes I haven't and when I have been interested, I've experimented with how to do that, erm, to greater and lesser success (Katin, FG2)

because I think, that is one of things that we've been continually exposed to in different ways, erm, multiple voices and sometimes people listening or not listening so well but many different perspectives and, you know, (Ruth, FG2)

being in the big group, that's particular, was, is still quite tiring for me (Jerry, FG3)

Because I think that, that, that's always the space that I found the most challenging and most disorientating, dizzying, erm, for me, and I think, you know, I keep thinking, what's it about? is it about people? I think one of the things there, it's hard to hold that space, because there are so many different people, with so many different views, feelings, going on all in that room, at the same time, and when you try to attend to that, and be part of that, it can feel like wow (Andy, FG3)

Training helps resolve personal and family difficulties

for, example there was one exercise where you had to write a couple of letters to important people in our network and it resolved something which I had held since I was 17. And I had a, a, memory of something when I was 17 and it didn't actually happen that way and I only found that through the, the, letters, and I'd held that grudge for, 23 years, so it was really (1) don't know what the word is, powerful, very powerful. (Kevin, FG1)

one of my sons, interviewed me and it was, looking back at that video now, and I'm like "oh my goodness", I have a grown-up boy here. (Aburi, FG1)

, but, er, we, I, I was more aware of how it is important to have a relationship with er, my daughter and my son, to take care of this. (Llello, FG1)

it built a bridge in our family about a particular event that had happened years and years ago that it kind of caused quite a bit of division that had lain, laid under the surface, but by being able to, you know, by being open an having an opportunity to discuss it openly and getting different perspective, like bridges were built, erm it feels you know my family (Ellen, FG1)

mmm, yeah for me, I've become less anxious about certain things (.) erm, now I use the French phrase que sera sera more often (Aburi, FG1)

erm, I mean I have a brother who has bi-polar type diagnosis and it just kind of makes you think about all of that, you know, how did that, if that's a relational thing, what was happening when that happened (Jerry, FG3)

Training leads to personal insights

being able to give space to, and explore how you influenced in your current position, your current role today, based on your influences and your perception and how your lenses, if you like, have, have built up, that is an absolutely, absolutely critical part of therapy, but also about being a good practitioner as well (Ellen, FG1)

going back to those earlier things said about, erm, family of origin, I think that's the most erm, for me, wonderful part of this course, because its enabled me to rediscover myself (.) (Aburi, FG1)

, I realised, er, er, that, er…also with the work we have done in the family of origin group, that I was walking in the same er, path as my father did with me. (Llello, FG1)

I think it's made me more aware of myself (Kevin, FG1)

I think now, is what I said earlier, about the ↑language↑, that, that the things that I have (.) been experiencing in my life, I did really go to the places, that I understood during this three year [sic], that they didn't have words (2) before (Helen, FG2)

I think one of the strengths of the longer training is the emphasis on the inner polyphony and being in touch with your own lived history and yourself (Ruth, FG2)

NEGATIVE CASE for me, no. I mean, obviously everything changes all the time, but not, and in conversations with people, but not specifically, no radically, erm, I guess cos I would already had an understanding from where I'd come from, prior to this, yeah, it's not been part of my journey on the course I think. (Katin, FG2)

I have had, new words and understandings, whatever they might have been, for my experiences and for my (5) for my, way of being, definitely (Helen, FG2)

I've, I've, maybe you know, like, this idea about having new ideas, new way of describing things, you know, things that I think are quite powerful, you know the whole idea of polyphony, sort of new words and new ideas to describe experience, your own experience, that's actually really interesting. (Robert, FG3)

Becoming more present in-the-moment

I pretended it's possible to pay attention to a person even if the mobile is ringing, it's not true! (Llello, FG1)

I've learnt so much about my practice and I feel its, its evolved substantiality and erm, I think I'm a lot more (4) present I suppose is the right term, I'm, I'm a lot more present. (Kevin, FG1)

I'm picking up more on, on, on ques like, say if you were talking and you were the client, I'd, I'd been looking at you but id also be aware of the two family members and you, you, my my, peripheral vision has improved no end (Kevin, FG1)

in the sense of having that awareness (.) of everybody in the room and (2), ah yeah I suppose (2) much more acutely aware I would say, than in the past, erm, I think in terms of how I see myself (Ellen, FG1)

and your embodied reaction response to what's happening in the room here and now (Ruth, FG2)

it's just being present and erm, that's given, back to the freedom of flying thing, my gosh, there's eh, that has set me free, erm, that erm, erm, I'm not, filed in my head with all this kind of inner dialogue of other stuff, I can just be present , and I can be present when it's not working and when it's just everything is still really difficult (Paloma, FG2)

: that paying attention, that staying with it, paying attention, family of origin, supervision, it's hard, it's really hard, you know, it's sort of doable for, a couple of hours, then I find it really hard to stay, completely stay in it, I can feel myself sometimes carried away, particular and I think your word about tiredness really sort of chimes, chimes with me about how tiring, how exhausting that can be (Andy, FG3)

all the intense vigilance as to whether, you know, how to go with this, and it was really, it was fantastic, it was interesting and it was, erm, but it was very exhausting yeah (Jerry, FG3)

yeah, yeah, and also, also, like you're much more attune to your own body language and how, and how the open inclusive body language versus you know. (Ellen, FG1)

Bringing my authentic self: "a journey of integration"

as I have done if it's been a father talking, from my being a father point of view (Kevin, FG1)

putting the personal and professional together is that, that's how I've always wanted to work (Ruth, FG2)

I I think I'm myself, I mean, it's very important for me, ((sighs)) I mean in working situations to be me (.) but of course, within the context, but much more than me than before. Like, I might be head nurse or something I had to do, and things I have to say or something like that, has changed, yes (Sophie, FG2)

yeah, I, I mean, as a role as me and as a practitioner, and me as the Helen, making my life (1) mo:re congruent, more, [I have more [Paloma: more in harmony, yeah] self-esteem (1) a:h, ja [I think the person [Paloma: I think the, ah]] (Helen, FG2)

I had a real intention for myself that, it would be, a journey of integration = Paloma: =mmm= Ruth: =where I could bring more of myself and my personal history and my life and my values into my professional life also, they would start feeding together more (1) explicitly. And I think that has been one of the side effects (Ruth, FG2)

because of this idea of boundaries, do you know what I mean, not that I think that's necessarily a challenge to boundaries, with professional ways of being, but it seems that you're bringing different qualities, different aspects of you as a person, so (.) maybe using or getting in touch with more of you perhaps when you're… (Robert, FG2)

and you kind of know about professional boundaries, and you kind of learn to respect those or whatever, you know, it's very ingrained then, so maybe it's more easier then to have this more personal (.) (Jerry, FG3)

family of origin,and rediscover erm, a lot of values, you know which, I probably hold to and don't understand why I'm holding onto those values (Aburi, FG1)

Becoming more open to others

I think, I think that's been the biggest change, I'm more open about myself (Kevin, FG1)

I'm more open to my ↑family↑ (Katin, FG2)

I would say that Open Dialogue practice, and the longer training, removes the taboo on being access or share elements of your embodied experience or perhaps your history (Ruth, FG2)

it's not about me, it's about all the others, but, the sharing part could be- if I feel unsafe suddenly, or I think I'm helpless, I don't know what to do, I feel hopeless or something like that, then I can share that with you, about my feelings, how do you think, erm, we should go on do you have any ideas? Or ask people, that kind of sharing but not start to talk about my life, maybe that would be in a long relationship, but if it's a network meeting, I mean, I don't know, but if I had a similar experiences that people come with, but you guys know more about that than I do, that's different, but it's all okay again, I mean think about what do they need? Er, and you could ask, I mean you can always offer, so (Sophie, FG2)

there's lots of trainees there that I know have gone through our training and I've never met them before, but I know, you know, it's okay to have those kind of conversations, yeah (Fred, FG3)

knowing they are thinking in a similar way allows you to be, to share things (Fred, FG3)

to go and, and (1) depths, share my depths with other people has made me, courage to share it with others, you know outside here (Paloma, FG2)

NEGATIVE CASE but the sharing of my lived experience, yeah, it's been there for a while and it's no different (Katin, FG2)

Feeling deeper connections through "richer relationships"

because I, I look at it as, that person is a human being like myself, we are human beings, and that's period (Aburi, FG1)

it just brings a much richer relationship with colleagues and professionals= Aburi: =mmm= Ellen: =as well as with families and with the person, because you're not fighting against something it's like the battle has kind of been take, the battle ground has changed in a sense, it's no longer a battle (Ellen, FG1)

erm I think there, i::t it all… for more healthy and healing relationships and a much more deeper qualitative, erm quality of relationships (Ellen, FG1)

i:: it's like, making a connection with them (2) you know and validating them and saying erm, I don't judge you, you know I see you as a human being (Aburi, FG1)

if I want there to be a possibility of change then I've found ways of ↑caring↑ (Katin, FG2)

I think Open Dialogue training has given me the real appreciation of this thing I had already, this idea of the other, which for me is a very precious concept (Katin, FG2)

and being interested and curious and that's become easier to hook into (Katin, FG2)

we were both quite elated when we went back to work after the first block I think, and I don't know what, it was a sort of sense of discovering a different way to be with other people, that connected you more to them I suppose (Jerry, FG3)

Family of origin was interesting, very powerful and kind of emotional and challenging, sometimes it felt, quite exhausting, sometimes I kinda of run out of kind of space for more connecting or something (Jerry, FG3)

this is just such a wonderful way, such a rich way of being with (.) with people (Andy, FG3)

I felt it, sort of, as a, as a mental health worker in a, you know, NHS team, it sorts of brings you into different territory with people, in the conversations that you're in with families, you know, much more emotional, much more, kind of, you know, real in a way, in a way about experience, in a much more, that way, whereas, like, previously, you know, it, seemed to be kind of much more lineal path to, you know, here is something that I've had, here is an emotion, erm, therefore, its explained, you know, whereas, lots of contexts to, lots of conversations around impact (Robert, FG3)

And I think because you do work closely and you do know somebody's family background (1) and you do share stories that you actually are able to have that kind of, sort of conversation with someone. Not in an ordinary working environment you never would, ever (Fred, FG3)

you know if you care for people more than you usually care, I feel I care more, yeah that's one of the effects its actually had, is that I care more about patients, when something bad happens, you actually care more about it (Jerry, FG3)

well I love, I, do, I love some, not all of them but ((laughs)) some more than others. But I think I've felt that before, as well, just working with families, but probably because the sessions are longer, so you do have more time together (1) erm, I think it does allow for it, (.) a different, deepening of the relationship, yeah (Fred, FG3)

because I, I look at it as, that person is a human being like myself, we are human beings, and that's period (Aburi, FG1)

Understanding the world through a relational lens

understanding maybe that some people's distress is to do with all of us rather than them, just them on their own (Jerry, FG3)

has radically changed the way we understand the importance of families and how a person's social network is so, um, connected to his personal resilience and their resources and recovery. (Ellen, FG1)

a very big shift and a very strong er, social network perspective has permeated through many areas of our service because of erm, this training (Ellen, FG1)

NEGATIVE CASE yeah, I mean, um, I I work in an Early Intervention service and we routinely involve families, (Kevin, FG1)

hen people want me, ask me, can you come and supervise, and I say neeh, I can offer dialogical…I can facilitate some dialogues, in different ways, that's what I can offer you, (Sophie, FG2)

feeling that you are actually part of the group but then you don't, can, exist less than you think outside or away from the group (Jerry, FG3)

so, things that might appear to have very, to be meaningful to you, only really become meaningful in context of other people's meanings, and you know, if you don't pay attention to other people's meanings, then your meanings are lost. You know, that kind of (Jerry, FG3)

I think there's, like me, what I've noticed what might be different, I guess I was always aware of like, or I felt that, there were something a bit one size fits all about you know the kind of, standard family approaches to, you know, that, that we often use in early intervention, you know, the psychoeducative approach, and I don't think it's, err *clears throat* quite adequate. (Robert, FG3)

definitely (.) changed many things, erm (1) who I am, kind of how I relate to other people, so yeah (Sophie, FG2)

Becoming more collaborative

that assessment to do, I want to talk about this, that and the other, whereas now, I'm like, so, what do we want to talk about today kind of thing . I mean obviously because of CPA documents and all that, there are times I have to say I just need to get this information down, but then its straight back into, so, what should we talk about now? and I think that's been the biggest, certainly the biggest positive change for myself (Kevin, FG1)

but then here I discovered more deeply, how this could affect the, the relationship with the others, especially it happens to me, it happened to me with some clients I know since many years, some sort of, er let's say, chro, chronic er, situations, when I, cos I'm very much hard they think, I was keeping on desperately trying to, to, change the other, to, to, to, not, not, to change because it's not politically correct (Llello, FG1)

that gives the other person the autonomy, to be able to manage themselves and bring about whatever change they need to move on with their journey rather than imposing my own anxiety on them. (Aburi, FG1)

So, I'm a bit less active, less creative, but in a good way (Katin, FG2)

very, much less directive (3) erm, sitting with a lot more stuff than I probably would have done in the past, erm, (2) that's been good for me, (Andy, FG3)

and I've kind of awareness that, a lot of our practice is very directive, and this sort of sense of how unhelpful that really is (Jerry, FG3)

. So, I think I, hopefully, I've moved back to being feeling comfortable to saying something. But not as structured as I might have (Fred, FG3)

and often times in the medical model we carry our anxiety across to the person which is sort of um, um, erm, infusing the anxiety into the other but if I hold my anxiety and tolerate the anxiety things might not get worse, you know, we can muddle through (Aburi, FG1)

I think the biggest change is going in without the agenda. (Kevin, FG1)

yeah, not, not, having an, a, agenda is really one, erm, most important things that happened to me and I was er, er, I was, er discovering also this way of er, way of being with others in, in the Hearing Voices movement (Llello, FG1)

"Ellen: (.) I'd also say it's the shared decision making aspect for me

Llello: mmm

Kevin: mmm, well as a clinician that really reduces the pressure on yourself (Kevin, FG1)

I'm not responsible for er (.) er::, the: (.) for giving many useful suggestions, well I must say, some, something is my responsible, prescribing drugs, er, er, but I realised that er (laughing), this was a side effect of the training, on drug prescription, could be done in a more collaborative way. (Llello, FG1)

yeah, the over responsibility, I think I've had a bit too much of that, I think that's perhaps also why I feel like flying. I don't carry so much with, in terms of that, (Paloma, FG2)

And I also think a transparency in practice has become, ahhh, really core to how I work in terms of, absolutely sharing notes (Ruth, FG2)

I discovered how it makes a difference to stay on this side of the table with the family, the client, the patient on the other side or to move here or to stay there, so it's err, surprising, it's a surprise because it's happened in, in, it wasn't the teaching, it happened in my mind (Llello, FG1)

Understanding the power of my words now

Llello: Cos er, sometimes I, I, hope I'm, I'm more aware that er (.) bringing something from my personal experience could be an attempt to er (2) say to the othe:r, follow my example (.) or sort of hidden suggestion. Er:, so, if I: (.) mm (.) realise, if I feel there isn't this hidden, er, aim beside, e:r I, I share, what er, what, er, what, something personal and its very e:rm (2) important to me (Llello, FG1)

but if it its things that erm (2) are suggestive, I keep it, I don't share it (.) (Aburi, FG1)

but I'm actually opposite what you were saying, I'm more silent than I used to be, because I thought my words were very important ((smiling)) (Sophie, FG2)

and I think I became quieter (4) whereas I think, initially I felt, I, I ought to be saying something, I ought to be contributing to this (2) and then but I started to think, well I think I will just stay quiet (Fred, FG3)

quieter (2) when I'm with (1) families, even when I'm with individuals (Andy, FG3)

I think, also, just, just, just listening really, you know, erm, I think there has been a few times, just kind of telephone conversations erm, that it's just been, you know, possible not to kind of say, oh well, you know, almost like in a defensive way, or this is this, you know, just to sort of listen and kind of, you know, erm, you know, it can be quite powerful just to be heard, just the feeling of being heard (Robert, FG3)

I cannot know if what I offer is useful, I can't claim that, and so there's so really subtle things that go on inside, whether I chose to share or not and try to notice the impact of my sharing as much as possible, if I need to sshh! ((covers mouth, laughs)) erm, (Katin, FG2)

Finding a voice- challenging more

and it's having the confidence in feeling comfortable, and giving yourself the right to say, well as such and such, th, there's this option, or whatever (Kevin, FG1)

and so both the shared decision making, the polyphony of voices, erm (.) and the emphasis on dialogism, rather than monologue, er, those three components have given me a lot more grounding in myself to, to, question (Ellen, FG1)

to be able to have any chance of influencing that conversation, erm , I suppose the, like, training then for me has helped to provide a framework to do that, and has given me a, in a sense, a position within the organisation maybe to be able to do that, a lot more than I would say maybe before, erm, so, I would say that for me has been, I feel as though I've got more, my sphere of influence is much broader (1) now, erm, than before (Ellen, FG1)

now I am able to (.) challenge certain things really, especially in the area of medication, that has been one of my things (.) (Aburi, FG1)

I have a very similar story, and I was certain that did save that person's life, or significantly, erm, have averted a catastrophic event, you know, it may have been life or death but it would have certainly been through A & E, erm, and I think it's those ,you know, it's those moments where you have to really… and I suppose, before just, now I just don't even question it. (Ellen, FG1)

", yeah I do, I do, think its absolute crucial role in, in, in sort of questioning. Aburi: =Yup=

Ellen: =And challenging for…(Ellen, FG1)

I think, the more visible change has been my role and position and kind of existence with my co-workers and actually my boss said to me a year ago, that you are challenging people (Helen, FG2)

:= and I should be able to bring that voice, though not be hierarchical about it, just be able to voice that opinion= (Kevin, FG1)

so I went back to the doctor and I said to her, there no way am I going to stick this needle into this patient. (Aburi, FG1)

Appendix P: Extracts from a reflective journal kept by the author of the research process

2016	
December	Have been in discussion with an external supervisor about an OD study. They have proposed two broad areas of potential study, one which would involve interviewing clients and families who have taken part in network meetings to understand what it has meant for them, and the other around staff experiences of OD training, particularly around changing relationships with risk. At first I was more drawn to working with SU and their families, I would like to do a very collaborative project and involve SU and families in the planning. After discussing the project with potential internal supervisors I have been drawn more to the focus groups with staff however, largely due to the potentially greater impact this work might have on the development of OD in the NHS by better understanding the barriers which might affect this.
2017	
January	Have been having lots of interesting and thought provoking discussions with internal and external supervisors. The main debate at this stage has been around the methodology and how this impacts what we are trying to study, whether to use IPA or discourse analysis. The IPA would focus more on participants' experiences and the argument for this is that it's a very new area and we want to establish what, if anything, has changed for practitioners at this stage. The other option is to do a discourse analysis to explore participants' dialogue and use of language e.g. if they are using medical, pathologizing language to speak about SU or that more reflective of the training. We think this might be more useful if we had pre and post data and perhaps more useful for later cohorts, once change through training has been established. The other big debate is around using focus groups as this is not typically used with IPA methodology. Jaakko is keen for us to use this method as it aligns with principles of dialogism which I support. I have also found good justifications for use in the literature. I am keen for the project to have more of a focus on identity change than purely working practices as I think this is broader and has more wide-reaching implications. Maybe it is just more interesting to me too!
February	We have also been discussing the option of using dialogical analysis, to have the method be in line with OD principles. From what I've read this would then be about understanding the change that happens during the session (or focus group in our case) based on the unfolding dialogue between participants. The project is more keenly interested in the transformation people describe over the course of the training and I'm not quite sure I see quite how the dialogical approach would fit with the research question as it is now but that's not to say we couldn't adapt the question to explore the use of this approach, although I think I might be more interested in the phenomenological aspects of possible identity change as a result of training.
March	Working on getting the draft MRP proposal in. Methodology preference appears to have changed again through discussion with internal supervisors. I am leaning more towards Discourse Analysis I feel like this might align philosophically with the OD principals but would allow us to analyse the content in more detail than dialogical analysis. Internal supervisors think doing before and after might be too biased (participants would give answers they thought we would want to hear about their views towards SU etc). It might be interesting to do focus groups on perhaps different roles after attending training- maybe one with a general mixed group and one specifically just of psychologists/ psychiatrists.
April	I'm reading about Foucauldian discourse analysis sounded like it would fit with a research question which was looking at participants discursive worlds and how this affects how they view themselves and others- for example their positions as member of NHS staff and of certain teams/ professional groups and how this will be itself constructing their perspectives on their own and professional identity.
May	After lots of discussion in preparation to hand in the proposal we have come back round to using IPA as the methodology. Based on previous arguments that this is a new area of research and we want to establish the existence and experience of possible change before narrowing the focus on micro elements of dialogue. Want to

	combine it somehow with dialogical analysis to uphold OD as a research method somehow and feel this will provide more rich data. Still struggling to decide on the mix of groups. Having lots of debate around power dynamics within the focus groups if we mix practitioners. We have also been making the assumption that change might be different for say psychiatrists and psychologists and want to be able to compare this in some way.
June	Have presented the project at an OD research group. Felt very nervous doing a presentation but it was really helpful to hear about what other work is going on within the network. It's got my reinvigorated for the project, really want to see OD expand in the UK! Survived the MRP proposal review! Main amendments they had were about sticking to one methodology- not combining IPA and dialogical analysis. They felt it wasn't in the scope of an MRP but could be interesting for future research. I'm a bit disappointed as it would have been a really interesting study but also relieved as they made me realise how much extra work it would be. The panel also suggested that carrying out focus groups only in individual professional groups as IPA is not appropriate for making comparisons across groups. They recommended undertaking focus groups with individual professional groups, and then a final group of mixed participants and then combine responses across groups.
September	Completing ethics panel form. All a bit of a rush to get everything approved before the last OD cohort teaching session! We're having an ongoing debate about inclusion criteria- it would be good to stick to NHS staff so that the findings are applicable to the UK but for practical recruitment reasons it might be good to keep this broad. I starting to see where the real world collides with research ideals!
October	Full ethics approval received! I am also emailing the OD network to try and consult with peer workers currently on either the one year POD or three year OD training who would be interested consulting on the research questions. I want to make sure we are working the questions sensitively. I have also emailed someone who came to teach us about the dual roles of service users and practitioners to see if she would like to consult around the questions as the project seemed to fit her work really well.
November	Unfortunately I have not heard back from any peer workers to consult on the project which is a shame. Spoke to the dual role SU/ clinical psychologist which was really helpful. I'm torn though as she has recommended to use the language of mental ill-health which I don't really like, but I want to respect her suggestions and preferences. It's been a real struggle to get recruitment going. Getting a little nervous about getting enough numbers in time. Feel the pressure of wanting to get good enough data to get meaningful results to support OD in the NHS.
December	After quite a lot of last minute anxiety about recruitment we have pulled it off! Have just completed the three focus groups. I've come out of them quite buzzing and feeling really honoured to have been part of the process and having access to trainee's thoughts and reflections. Some of my immediate thoughts coming out of them have been: people seemed to find it a useful space to explore their experiences of the last 3 years. They varied a lot in the feel and dynamic which was really interesting to see and had an impact on the data (e.g. one group were already well bonded individuals and one person became quite emotional). Some of it was as we hypothesised, such as the difference in distance travelled for say psychiatrist and family therapist/ peer worker but there were some very interesting nuances which came out for the difference the training made for say the FT, so I'm glad we included them- otherwise I was reflecting we may have been left thinking if it was any different from what was gained in FT training. For example, one FT said it had made them care more about their clients than in their previous practice through hearing them more. The invitation to disclose more in OD brought out some interesting contrasts, with some people feeling it gave them permission to share more with clients while some felt they should share less as they were more aware of their power in the room. A lot of them talked about process over content and the

	experiential aspects of the training. The family of origin exercises seemed to come out in all 3 groups as particular impacting on people. I'm not sure how much any of these will come out as repeated themes though, will have to wait and see. Some people spontaneously used the word transformational too which I was very excited to hear!
2018	
February	I have agreed to present the provisional findings of the study at an OD research conference. This makes me terrified! This is the blurb I have sent "I am currently undertaking an IPA study of the experiences of practitioners who have completed the three-year Open Dialogue training. The project is supervised by xxx. We are particularly interested in the potential shifts in professional and personal identity, as well as in interactions with people in the role of service users, which may occur as a result of completing this training. The study aims to focus on the experiences of those working in the NHS, with the aim of understanding any challenges which may occur for staff when attempting to integrate the Open Dialogue principles taught on the course into current professional identities and practice."
March	It was so helpful to attend the OD conference, there were so many inspiring talks. I was really interested to hear perspectives from the POD training. It's interesting to compare what is coming out of that. I'm slightly concerned that the shorter training is going to miss elements which have come out as so crucial to the three-year training and this is going to impact outcomes of the pilot. One the arthrological studies on POD highlighted staff's ongoing uncertainty around tolerating anxiety within the NHS. Jo and I were presenting so I had to do a rough and ready very quick analysis of the data from scanning it. I'm sure it will change when I have go through it properly.
August	I have been spending the last few months writing and reading transcripts. It's taken so much longer than I thought. IPA feels like a really rewarding method of analysis, I'm actually enjoying how much minute detail you get to read into everything that's been said. It feels like an act of deep listening- I'm actually bringing it into my clinical work. Themes are definitely appearing. It's interesting how much of a different relationship you have with the data than when I was in the room with people. I've been really moved by a lot do their words and my assumptions have definitely been challenged, such as how open to OD the psychiatrists were. One thing I'm trying to be careful is to not let conversations I had prior to the FG impact on what I report on. For example we thought that family therapists and psychologists would have very different experiences of the training but actually only one reported less distance travelled.
September	Has been so stressful getting a draft ready for part B. I definitely struggled at first to take the leap of putting my own interpretation of the participants' words. I worried I would not be representing their words well enough and that I didn't have insight into what they were saying, it felt safer to do it like a thematic exercise. As I got into it though it actually felt like a very authentic exercise and I realised that I was actually able to more authentically represent what they were trying to say- especially from being there on the day and hearing how they were communicating these issues. Some things have come out that I wasn't expecting- for example stuff about the process- just how helpful people found the style of learning but also how scary some people found it.
November	Have had a first draft back from part B. Need to go even further with my interpretations and bring the individuals to life. It's been an additional challenge trying to bring the individual and group into the narrative. Supervisors were all overall happy with the main themes but need to work on their names so they better represent the contents. It's really interesting hearing the things which stand out to different people from the findings, I'm sure it links into people's theoretical backgrounds, passions, perspectives etc.
December	Working on second drafts, thinking about all the implications for psychologists. Again, I'm trying to stick to the data and not let it be influenced by how much I think OD should be used to transform services! Looking back it's interesting how the early themes that came out of doing a very quick scan have remained in the final analysis,

	although not as superordinate themes. I tried not to look at them again until I had finished analysis so that it wouldn't bias my thinking.

Appendix Q: Instructions for Authors Community Mental Health Journal

Manuscript Submission

Authors should submit their manuscripts online. Electronic submission substantially reduces the editorial processing and reviewing times and shortens overall publication times. Please follow the hyperlink "Submit online" on the right and upload all of your manuscript files following the instructions given on the screen. http://comh.edmgr.com

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

Inquiries regarding journal policy, manuscript preparation, and other such general topics should be sent to the Editor-in-Chief:

Jacqueline M. Feldman, M.D.

Patrick H. Linton Professor

Department of Psychiatry & Behavioral Neurobiology

University of Alabama at Birmingham

CCB 4th Floor, 1530 3rd Avenue South

Birmingham, AL 35294

Email: jfeldman@uabmc.edu

- http://comh.edmgr.com

Manuscript Preparation

Manuscripts should be submitted in Word.

• Use 10-point Time New Roman font for text

• Use italics for emphasis

• Use the automatic page numbering function to number the pages

• Do not use field functions

• Use tab stops or other commands for indents, not the space bar

• Use the table function, not spreadsheets, to make tables

• Save your file in doc format. Do not submit docx files.

Adhere to Journal style and include the following sections: Abstract, Introduction, Methods, Results, Discussion, and References.

All studies must be approved by human subjects committees (also known as institutional review boards). At the end of the Methods section, authors must state which human subject committee (institutional review board) approved the study.

The title page should include:

• The names(s) of the author(s)

• A concise and informative title

• The affiliation(s) and address(es) of the author(s)

• The e-mail address, telephone, and fax numbers of the corresponding author

Please provide an abstract of 100 to 150 words. The abstract should not contain any undefined abbreviations or unspecified references.

Please provide 4 to 6 keywords which can be used for indexing purposes.

Limit Articles to 16 pages of text, double spaced per APA guidelines, exclusive of references, tables, and figures. Brief Reports should be no longer than 10 pages of text, and should not include any tables or figures.

Abbreviations should be defined at first mention and used consistently thereafter.

Tables:

• All tables are to be numbered using Arabic numerals

• Tables should always be cited in text in consecutive numerical order

• For each table, please supply a table heading. The table title should explain clearly and concisely the components of the table.

• Identify any previously published material by giving the original source in the form of a reference at the end of the table heading.

• Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

For the best quality final product, it is highly recommended that you submit all of your artwork – photographs, line drawings, etc. – in an electronic format. Your art will then be produced to the highest standards with the greatest accuracy to detail. The published work will directly reflect the quality of the artwork provided.

References

List alphabetically, adhering strictly to APA style (Publication Manual of the American Psychological Association, 4th or 5th edition). Authors are responsible for providing accurate references.

Conflict of Interest

Authors must address possible conflicts of interest which can include (a) consulting fees or paid advisory boards for the past two years or known future; (b) equity ownership and-or stock options in publicly or privately traded firms; (c) lecture fees from speaking at the

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Upon request authors should be prepared to send relevant documentation or data in order to verify the validity of the results presented. This could be in the form of raw data, samples, records, etc. Sensitive information in the form of confidential or proprietary data is excluded.

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- an erratum/correction may be placed with the article

- an expression of concern may be placed with the article

- or in severe cases retraction of the article may occur. The reason will be given in the published erratum, expression of concern or retraction note. Please note that retraction means that the article is **maintained on the platform**, watermarked "retracted" and the explanation for the retraction is provided in a note linked to the watermarked article.

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Authors are welcome to suggest suitable reviewers and/or request the exclusion of certain individuals when they submit their manuscripts. When suggesting reviewers, authors should make sure they are totally independent and not connected to the work in any way. It is strongly recommended to suggest a mix of reviewers from different countries and different institutions. When suggesting reviewers, the Corresponding Author must provide an institutional email address for each suggested reviewer, or, if this is not possible to include other means of verifying the identity such as a link to a personal homepage, a link to the publication record or a researcher or author ID in the submission letter. Please note that the Journal may not use the suggestions, but suggestions are appreciated and may help facilitate the peer review process.

COMPLIANCE WITH ETHICAL STANDARDS

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

RESEARCH INVOLVING HUMAN PARTICIPANTS AND/OR ANIMALS

INFORMED CONSENT

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Appendix R: Email sent to participants to check transcripts

Dear (name),

As requested on the consent form at the time, I am getting in touch to send you a copy of the transcript of the Open Dialogue focus group that you kindly took part in last year as part of my research. I have tried to take care to transcribe the recording verbatim, but please feel free to comment on anything which you feel is inaccurate or does not represent what you said at the time. Please note identifiable details have been altered or removed.

If I do not hear back from you by 31/12/18 then I will assume you do not wish to make any amendments.

Thank you again for participating. If you also marked on the consent form that you wanted to have any opportunity to check the findings I will be in touch again for you to comment on if you wish.

Please let me know if you have any further questions about the study.

Best wishes

Ali Wates
Salomons trainee clinical psychologist

Appendix S: Email sent to participants to check findings

Subject: Experiences of OD training focus group- opportunity to check findings

Dear (name),

I hope you are well. It's been just over a year since you all kindly took part in the above focus groups, how time flies!

You are receiving this email from me because at the time you checked the box on the consent forms which stated you would like the opportunity to read and possibly comment on the results of the study.

A draft write up of the findings has been attached. This gives you the opportunity to read them as requested- **you have no obligation to return any comments, but please feel warmly welcome to if you so wish.** Please note that the study is an Interpretative Phenomenological Analysis- therefore it will be assumed that the researchers will have been making a certain level of their own interpretations on the data (i.e. making sense of you making sense of your experiences). Please do comment however if you feel your words have been misrepresented at all, you feel your anonymity has been compromised in any way, or you feel overall the findings really do not represent the content of your groups.

Please do not be disappointed if you do not find yourself quoted as frequently as others- everyone's voice made a really important contribution to the overall findings- quotes are just the soundbites which most effectively illustrate a theme. Also, this is a draft and there may be some changes to the final version.

Please let me know if you have any questions. If I do not hear back from you in 2 weeks, by 19/01/19 then I will assume you have no comments to add.

It was a pleasure analysing all your thoughtful words and I think some really interesting themes have come out of the data. I hope the training is continuing to have a positive impact for you and your work.

Thank you again for taking part again.

All the best

Appendix T: End of Study Report for Ethics Panel

Salomons Centre for Applied Psychology Ethics Panel
Canterbury Christ Church University
Salomons Centre,
1 Meadow Road,
Tunbridge Wells,
Kent
TN1 2YG

Dear Professor Margie Callanan

Study Title: "I've lived that thing that we do with families": understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Please find the enclosed end of study report for the project mentioned above. This study was reviewed by the Salomons Centre for Applied Psychology ethics panel in September 2017. After receiving ethical approval, once conditions as suggested by the committee had been satisfactorily adhered to, the study formally commenced in December 2017. Data collection progressed with no ethical issues or concerns raised. The study concluded in April 2019.

Please do not hesitate to contact me should you have any concerns or queries.

Yours sincerely,

Ali Wates
Trainee Clinical Psychologist
Canterbury Christ Church University

“I’ve lived that thing that we do with families”: understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Aims

The study aimed to explore the following questions:

1)What were trainees’ experience of attending the three-year Open Dialogue course?

2)How (if at all) participants felt the training affected the way they approach and understand their practice?

3)How (if at all) participants felt training affected their understanding of themselves and their lives?

4)How (if at all) participants felt training affected their experience of encounters with service users?

Methodology

The study utilised an idiographic interpretative phenomenological analysis (IPA: Smith, Jarman and Osborn, 1999) approach, as a means of understanding the subjective experiences of a sample of individuals as it allows a focus on phenomenological experiences and how participants make sense of these experiences within the complex context of their own personal and social worlds. For example, IPA allowed consideration of the participants’ professional roles, and how this may affect their experiences.

A total of three FGs took place. 13 participants were recruited over the groups.

Findings

Four superordinate themes emerged: (1) A powerful experiential process (2) Personal therapeutic change, (3) Experiencing deeper and more open relationships, (4) Changing

relationships with power in working practice. Novel findings suggest participants embraced culture shifts around power sharing in their working practices and experienced deeper connection with clients as a result of training. Dialogical teaching methods appeared to help foster transformational learning and lead participants to alter their practice in relation to power dynamics. Participants also described benefitting from experiential aspects of training which may also have implications for the design of clinical psychology training programmes.

Conclusions

The study strongly suggests the transformational potential of OD training. Novel findings suggest participants embraced culture shifts around power sharing in their working practices and experienced deeper connection with clients as a result of training. Dialogical teaching methods appeared to help foster TL and lead participants to alter their practice in relation to power dynamics. The study was limited by the cohort of trainees having voluntarily attended a privately funded course and may not represent potential challenges in a wider NHS workforce. More research is required to understand how the training impacts a wider cohort NHS staff. Clinical psychologist may be well placed to support with staff resilience in OD teams and could consider a greater inclusion of social networks in their own clinical work.

Appendix U: End of Study Report for Participants

Study title: "I've lived that thing that we do with families": understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Dear Open Dialogue trainees,

Thank you for taking part in my study, I hope the final report has done justice to your words and generosity of time. I enclose a summary of the study and the findings, please do not hesitate to contact me should you have any concerns or queries,

Yours sincerely,

Ali Wates
Trainee Clinical Psychologist
Canterbury Christ Church University

“I’ve lived that thing that we do with families”: understanding the experiences of practitioners undertaking a three-year Open Dialogue UK training programme

Aims

This project aimed to understand the lived experiences of trainees who had undertaken a three-year UK based Open Dialogue training programme.

Methodology

The study used focus groups to explore people’s experiences and used an interpretative phenomenological analysis (IPA). A total of thirteen participants took part in the study over three focus groups.

Findings

The findings suggest participants, drawn from a broad range of mental health practitioners, observed marked changes in themselves and their practice, with some describing the process as transformational. The study revealed four major themes: (1) that training is a powerful experiential process (2) trainees experience personal therapeutic change, (3) trainees experience deeper and more open relationships as a result of training and (4) trainees experience a change in their relationships with power in working practice. Dialogical teaching methods such as group discussions and experiential learning appeared to help achieve transformation in trainees perspectives and actions.

Conclusions

The study strongly suggests the transformational potential of OD training. Novel findings suggest participants embraced culture shifts around power sharing in their working practices and experienced deeper connection with clients as a result of training. Dialogical teaching methods appeared to help foster TL and lead participants to alter their practice in relation to power dynamics. The study was limited by the cohort of trainees having voluntarily attended

a privately funded course and may not represent potential challenges in a wider NHS workforce. More research is required to understand how the training impacts a wider cohort NHS staff.