Journal of Interprofessional Care

ISSN: 1356-1820 (Print) 1469-9567 (Online) Journal homepage: http://www.tandfonline.com/loi/ijic20

Inter-agency work in Open Dialogue: the significance of listening and authenticity

Anne-Lise Holmesland, Jaakko Seikkula & Mark Hopfenbeck

To cite this article: Anne-Lise Holmesland, Jaakko Seikkula & Mark Hopfenbeck (2014) Inter-agency work in Open Dialogue: the significance of listening and authenticity, Journal of Interprofessional Care, 28:5, 433-439, DOI: 10.3109/13561820.2014.901939

To link to this article: http://dx.doi.org/10.3109/13561820.2014.901939

Journal of Interprofessional Care

http://informahealthcare.com/jic
ISSN: 1356-1820 (print), 1469-9567 (electronic)

J Interprof Care, 2014; 28(5): 433–439
 DOI: 10.3109/13561820.2014.901939

informa healthcare

ORIGINAL ARTICLE

Inter-agency work in Open Dialogue: the significance of listening and authenticity

Anne-Lise Holmesland[1,2], Jaakko Seikkula[3] and Mark Hopfenbeck[4,5]

[1]Department of Child and Adolescent Mental Health, Soerlandet Hospital Trust, Kristiansand S., Norway, [2]Institute of Clinical Medicine, University of Oslo, Nydalen, Oslo, Norway, [3]Department of Psychology, University of Jyväskylä, Jyväskylä, Finland, [4]Department of Geography, Media and Communication, Karlstad University, Karlstad, Sweden, and [5]Department of Health, Technology and Society, Gjøvik University College, Gjøvik, Norway

Abstract

The article explores what professionals regard as important skills and attitudes for generating inter-agency network meetings involving intra- and interprofessonal work. More specifically, we will examine what they understand as promoting or impeding dialogue and how this is related to their professional backgrounds. The professionals participated in a project using an open dialogue approach in order to increase the use of inter-agency network meetings with young people suffering from mental health problems. In this explorative case study, empirical data was collected through interviews conducted with two focus groups, the first comprising healthcare professionals and the second professionals from the social and educational sectors. Content analysis was used, where the main category that emerged was dialogue. To illustrate the findings achieved in the focus groups, observations of inter-agency network meetings are included. The findings describe the significance and challenges of listening and authenticity in the professionals' reflections. The healthcare workers expressed worries concerning their capacities for open and transparent dialogues, while the other professionals' emphasized the usefulness of particular techniques. Inter-agency network meetings may be improved if more awareness is placed on the significance of meeting atmosphere, dwelling on specific topics, dealing with silence and understanding how authentic self-disclosure in reflections can promote the personal growth of the participants.

Keywords

Focus groups, inter-agency network meetings, interprofessional work, open dialogue, social network intervention

History

Received 14 March 2013
Revised 20 December 2013
Accepted 4 March 2014
Published online 2 April 2014

Introduction

The aim of this study is to explore how professionals working across the boundaries of the health, social and educational sector carry out inter-agency network meetings. In order to find new solutions for mental healthcare for people from 14–25 years of age, a clinical pilot project entitled Project Joint Development was initiated in southern Norway. The participating professionals applied an intervention model based on ''open dialogue'' (OD). Through the use of the dialogical approach that is embedded in OD, the aim was to focus on increasing holism, continuity and dialogue on the border between different professions and agencies (Seikkula, 2000). The persons treated were suffering from various levels of mental health problems or were at risk of developing such problems.

Open dialogue as professional work

The idea of OD is to cross the boundaries separating professions and agencies and thus an inter-agency team was mobilized in every case, consisting of a minimum of two professionals from at least two different agencies with education and positions relevant to the specific case (Seikkula, 2000). The aim for the professionals is to carry out their work in network meetings on an equal basis and in the presence of and together with the help-seeker and private network and to adjust their professional roles and tasks according to the particular help-seekers need (Seikkula, 2000). Thus, different group processes and team performances will unfold in the various network meetings affected by the people present and the particular goals that the entire network aims to achieve. This makes OD particularly suited to illustrate particular aspects of intra- and interprofessional inter-agency work.

Team types can be described in different ways, but the most common terms seem to be multiprofessional, interprofessional and transprofessional teams (Thylefors, Persson, & Hellstöm, 2005). Multiprofessional teams consist of professionals from different professions working additively and who remain within their disciplinary border. Interprofessional teamwork represents an interactive mode of collaboration between professionals from different professions. Based on shared tasks or goals, they seek to synthesize the different professional knowledge and skills as the individual professionals are unable to accomplish through an individual approach alone (Willumsen, 2009). Transprofessional teamwork represents a naturalistic focus, which implies that the afflicted persons are understood within their environmental context and in their relational entities. The help-seeker and his or her private network should be encouraged to actively

Correspondence: Anne-Lise Holmesland, Ph.D. student, Child and Adolescent Mental Health Research Unit, Oslo University Hospital, Division of Mental Health and Addiction, Department of Research and Development, Box 4959, 0424, Oslo, Norway. E-mail: alholmesland@gmail.com

participate throughout the entire process. An important element in transprofessional teamwork is role release and role expansion, meaning that professionals release their role when the transfer specific skills to other team members who expand their role through the transmission (Doyle, 1997; McGonigel, Woodruff, & Roszmann-Millican, 1994).

As a response to what they denote as a linear understanding of teamwork, Reeves, Lewin, Espin, and Zwarenstein (2010) have introduced a ''contingency approach'' to teamwork. Based on a review focusing on a variety of team types, they identified core elements, which define the essence of a team. This includes: shared team identity; clear roles/goals; interdependence; integration and shared responsibility. By adding team tasks to the list, they include an aspect that may have significant impact on how the teamwork can be affected by predictability, urgency and complexity. The core aspects can be individually placed on a continuum, but when considered together they can help to define a specific team. Interprofessional work as teamwork includes the highest levels of the elements above and is generally unpredictable, urgent and complex. Collaboration differs from teamwork in that shared identity and integration is less important, while coordination and networking represent even looser modes of focus (Reeves et al., 2010).

Aspects of team processes including communication may represent a challenge for achieveing sucessful inter-agency work involving different professions (Horwath & Morrison, 2007; McLean, 2012; Ødegård, 2005; Reeves et al., 2010). Effective communication and collaboration are characterized by factors such as openness, trust and active participation (Thylefors, 2012). The ability to adjust the language to the listeners, i.e. both communicate with the help-seeker and the private network as well as with other professionals, is considered to be an important communication skill (Suter et al., 2009). Despite this, it is mainly profession-specific communication that is taught and which relates to the communication between the patient and his or her private network rather than the communication across different professions (Hall, 2005).

For conducting OD, some basic guidelines have been established to optimize the possibilities to utilize the psychological resources of the help-seeker and the private network. They are as follows:

- Organizing rapid response assistance.
- Including the social network in every case, and this means both the private and professional network. The private network may include, e.g. relatives and friends while the professional network may include representatives from agencies affected by persons seeking help, e.g. a teacher or nurse.
- Flexibility in all situations by adopting the treatment response to the unique needs of the help-seeker by, e.g. using different methods and varying the meeting places.
- Guaranteeing responsibility and psychological continuity. The very first person contacted by either the help-seeker or the members of the private network or referring authority should take the responsibility to organize the first meeting.
- Toleration of uncertainty during the process. Instead of aiming for rapid solutions, the aim is to increase the ability to tolerate the time when no response is available.
- The generation of dialogue is the primary aim of the network meetings (Seikkula, 2000).

The help-seeker and the private network are encouraged to take the lead and set the agenda and the starting point is the language of the private network. All decisions and issues are analyzed with everyone present. The aim is for the professionals to generate dialogue so that all the voices are heard. Hence, the professionals should listen very carefully to the different views that are expressed in the entire network. This assumes that the professionals have developed particular listening skills, including sensitivity to embodied experiences. This expertise is the result of personal development and an awareness of certain forms of expression, such as the use of specific words or verbal and nonverbal reactions that can result from unexpressed emotions that the help-seeker or private network is not ready to talk about. Thus, when all parties have presented their views, the professionals may present their personal perceptions by means of reflection while others listen (Seikkula, 2000, 2008, 2011). The professionals should manage to provide accounts on their thoughts and emotions in an authentic mode through '''being oneself' while also the professional'' (Billow, 2010, p. 53). This includes dwelling on specific topics, which are interpreted as having a particular emotional significance, and assumes that the professionals inter-subjectively manage their personal thoughts and feelings to achieve authenticity for themselves and the others. By this means being present in the moment, facilitate the sharing of emotions and the development of real dialogues (Billow, 2010; Seikkula, 2000, 2008). Dialogue is generated in the way we respond to each other and the words emerging in the present moment might represent difficult experiences for the help-seekers. Thus, by responding as fully embodied persons with voices that represent their professional expertise as well as with their personal and inner voices new perspectives may occur (Seikkula, 2011). The professionals' inner voices may trigger emotions and memories related to their own professional and personal selves. Thus, when a mother speaks of problems with her child, the inner voices of the professional pertaining to being a mother herself become part of the dialogue. When participants hear their own voices and are invited to express their own understanding they may increasingly ''become respondents to themselves'' (Seikkula, 2008, p. 481), and when they experience being taken seriously they may become more interested in others' experiences. This may increase the possibility of gaining a common understanding of the difficult situation and creating the motivation to maintain the dialogue so that genuine changes can occur (Seikkula, 2008).

To improve professionals' qualifications in working with OD the Project Joint Development was implemented from August 2003 to June 2005 and included a two-year educational programme. The interprofessional training programme included professionals working in the health, social and educational sectors that were working in agencies related to mental healthcare in a strict as well as broader sense for adolescents and young adults. The programme was led by professionals from the local university and the mental health clinic at the local hospital and represented a dominant mental health care framework. The programme focused on ethics, dialogues and processes and consisted of 75 hours of lectures and 73 hours of supervision. JS acted as the lead clinical supervisor in the project and participated together with ALH in the training and supervisory groups. The participating professionals were invited because of their particular position in the agencies they represented and/or their particular interest in social network intervention.

The utility and effectiveness of OD for people suffering from psychosis are demonstrated in several outcome studies (Seikkula et al., 2006; Seikkula, Alakare, & Aaltonen, 2011). A study concerning patients suffering from dual diagnosis found improved family relations (Thylstrup, 2009). Other studies concerning patients with severe mental health problems and traumatized refugees indicate that OD may have a significant impact on their mental health (Brottveit, 2013; Guregård, 2009; Holloway, 2009). Studies focusing on the organizational perspectives have revealed challenges associated with teamwork (Holmesland, Seikkula, Nilsen, Hopfenbeck, & Arnkil, 2010; Holmesland, Seikkula, & Arnkil, forthcomming; Søndergaard, 2010).

Network meetings may be utilized in severe cases invovling urgent, complex and unpredictable needs as well as in prevention or rehabilitation. In all cases, the aim for the professional is to facilitate network processes, representing an opportunity for the participants to partake in transparent and authentic dialogues (Seikkula, 2000). This means that aspects such as integration, interdependence and the experience of a shared group identity should achieve a level high enough so that the participants i.e. the help-seeker, the professionals and the private networks' experience that there are real opportunities for active participation in the dialogue by all parties (Reeves et al., 2010; Seikkula, 2000). Because of the encouragement of the entire network to contribute to developing a need-adapted approach, the professionals should have a flexible approach towards professional roles and tasks. Because the aim in OD is to unite the resources available, it could sometimes be adequate to transfer spesific tasks from one professional to another or to a person in the private network (Holmesland et al., forthcomming). Role release and role expansion can be time consuming, as it takes time to transfer skills and knowledge to other members of the network. Thus it may be more relevant in some particular contexts such as in less urgent, but more complex, long-term, inter-agency cases (Holmesland et al., forthcomming; McGonigel et al., 1994; Willumsen, 2009).

Because of the great diversity of professions and agencies in Project Joint Development we believe that an exploration of their perceptions can provide important information on how professionals may increase their contribution to intra- and interprofessional inter-agency network meetings. Because of the inclusion of the help-seeker and the private network, this may contribute to make factors such as integration and shared team identity for intra- and interprofessional inter-agency work even more challenging and thus communicative skills are particularly demanded (Reeves et al., 2010; Seikkula, 2000). The present article aims to explore what professionals regard as important skills and attitudes for generating inter-agency network meetings. More specifically, we want to examine the professionals' understanding of what promotes or impedes dialogue in inter-agency network meetings and how this is related to their professional backgrounds?

Methods

The aim of the study was originally to focus on whole networks. When observing the network meetings however, there seemed to be differences in how the professionals representing different sectors understood the concept of OD and in particular how they understood team processes. Thus, we turned the study towards an explorative study of the professionals only, and supplemented these findings with observation and examples of dialogues in network meetings.

Data collection

Focus groups are a means to explore group norms and meanings, which may exist between different groups of professionals (Bloor, Frankland, Thomas, & Robson, 2001). Thus, two focus groups were created based on the total population of forty professionals working in the agencies participating in Project Joint Development. This included relevant departments at the local hospital, the county services and two invited municipalities. Since the point of departure was to ensure that professionals representing such important agencies as the educational sector and psychiatric services were included, the professionals in the focus groups were selected according to their agency affiliation. In order to facilitate a free-flowing dialogue, we focused on participants in the focus groups who were rather professionally homogeneous with regard to their status within the project and thus we focused on those who were students in the project (Bloor et al., 2001). A purposive sample (Bloor et al., 2001; Hummelvoll, 2008) based on twelve participants out of twenty-six who fulfilled the inclusion criteria of the focus groups were invited to join the focus groups (see Table I).

Table I. Descriptive data sample.

The total number of participants from each professional group in Project Joint Development		Number of participants from each professional group in the focus groups
Profession	*Number*	*Number*
Nurses	11	2
Teachers	8[a]	3[b,c]
Child welfare officers	5	2
Social workers	4	3
Psychologists	4	
Social educators	3	
Medical doctors	1	
Theologists	1	1
Other bachelor degree	1	1
Missing	2	
Total	40	12

[a]By teacher we mean subject teacher, a special education teacher, social or head teacher or a clinical pedagogue.
[b]One of the teachers had two different educations. This informant did not particpate in the first meeting.
[c]One of the informants' educations is subject to some uncertainty.

The inclusion criteria were as follows: groups should have an equal number of participants from the two municipalities, involve the four supervision groups linked to the educational programme; should be ordinary participants (i.e. not supervisors, project leaders)[1]; should have participated from the project's outset; should include significant professionals representing important agencies; should include professionals working with both children and adults and representing both primary and specialist services; should have a balanced gender mix.

One group included six professionals working in the healthcare sector (Health Care Group), whilst the other six professionals were employed in the social and educational sector (Social and Educational Group). The participants were verbally invited to participate by ALH. One person rejected the invitation due to a lack of time.[2] During the first meetings, six persons from the Health Care Group and five persons from the Social and Educational Group were present. When the first focus groups were established, two members (from the Social and Educational Group) had no practical experience, whilst the others had participated in from one to more than 25 network meetings.

Two professionals (1 missing) in the Social and Educational Group had previously been employed in the mental healthcare sector.[3] Four professionals (1 missing) in the Social and Educational Group had more than one kind of educational background, were post-graduates or had participated in training programs in fields that they themselves found relevant for the project.

The two focus groups met three times, the first encounters took place in October 2004 and 2005. They met once again in 2007 in order to discuss key topics more closely. ALH was the leader

[1]On one occasion both representatives working in the same agency had other tasks in Project Joint Development. The informant included was chosen because of his relationship with the municipality and agency involved and because of the particular supervisory group.
[2]Thus, in one municipality, four persons representing one of the supervision groups were included, while only two from the other supervision group.
[3]Only one participated in the meetings reported from here.

of the first meeting in each group, which lasted for approximately 2.5 hours and took place in the child and adolescent clinic. The meetings were audio-taped and transcribed verbatim by ALH (Halkier, 2002).

To grasp the professionals' reflections on important OD skills in network meetings, they were encouraged to discuss the skills and knowledge they found to be relevant and to refer to actual situations and examples (Halkier, 2002). The first focus groups started with a vignette about Kari who is 17½ years old. Her parents are divorced and she is living with her mother and brother. Kari seems to have increasing difficulties with her schoolwork and in keeping up her physical exercise. She is increasingly associated with people who have a bad reputation for substance abuse. The vignette was followed by questions on how the professionals acted to facilitate successful network meetings as opposed to network meetings with poorer outcome.

The observational part can be separated into examples illustrated through audiotaped transcripts and more general observations of network meetings. The aim is to illuminate and highlight some findings from the focus groups according to a clinical context.

ALH observed 151 meetings in 16 cases while JS participated in 18 meetings. Two cases are excluded due to lack of renewal of consent. Permanent and primarily interprofessional teams, consisting of professionals representing at least two or more different agencies led the cases. In eight cases the permanent team consisted of healthcare professionals only (healthcare teams). In two cases the permanent team were intraprofessional i.e. consisted of professionals representing the same profession and post-graduate training (Reeves et al., 2010). Two other cases were intraprofessional but the professionals had different post-graduate education. In a number of the health care teams however, professionals representing the social and/or education sector participated with a ''guest status'' in one or several meetings. In six cases the permanent teams consisted of professionals working in the healthcare sector and social and/or the social and educational sector (mixed teams). The number of meetings in all cases varied between four to more than 25, the length of the meetings varied from 15 minutes to 2½ hours.

Because Project Joint Development included the study of network meetings with help-seekers and their families together with various professionals, an explorative case study was carried out. Case study design is well suited in situations in which the events are carried out in natural settings and where the researchers have greatly reduced possibilites to manipulate the study events (Yin, 2014).

The Norwegian Data Inspectorate and the Regional Research Medical Ethical Committee gave approval for the study. The focus group participants, the help-seekers and their parents, if they were under 18 years of age, were informed about the studies verbally and in writing, and they supplied their written consent for their own participation. The network members in each case were informed and accepted observation and audio recording orally. The team leaders for each case were also informed in writing and supplied their written consent with respect to their own participation and on behalf of the other professionals.

Analysis

The analysis of the focus groups was inspired by Graneheim and Lundman (2004) and Kohlbacher (2006). Content analysis makes it possible to carry out a systematic analysis of the material, focusing on explicit and latent underlying content of the emerging important categories. The inclusion of sequences of dialogues such as how participants negotiates between themselves and ask questions makes it possible to take into account the context for the utterances and thus also emphasize relational aspects (Graneheim & Lundman, 2004; Bloor et al., 2001; Kohlbacher, 2006).

The focus group interviews presented in this paper amount to 118 pages of transcripts (first meeting in each group). The first step involved reading through the transcripts of the focus groups' discussions to obtain an overall understanding. Meaning units such as words or sequences were identified and we created codes, subcategories and categories. The meaning units were abstracted to four codes followed by two categories and main theme. Finally, we merged the focus groups together and reduced the two categories to one and the four codes to two. During the final analysis we identified meaning units that were linked to each code. The meaning units may represent answers to actual questions from the researcher or other informants, be a minor part of a discussion, or be a part of the case discussion (Graneheim & Lundman, 2004).

To improve credibility, the transcripts have been examined by ALH whilst MH and JS have commented on these initial analyses (Hummelvoll, 2008). Moreover, ALH wrote a summary based on the key findings for each group before the second meeting in the focus groups. Before the third meeting, each group also received a summary including their own quotes together with ALH's preliminary interpretations from the previous meetings. All summaries also included questions for the professionals to discuss and thus served as a credibility check. Preliminary results have further been presented to other participants in Project Joint Development as well as to peers in work-shops and seminars (Hummelvoll, 2008; Graneheim & Lundman, 2004). ALH created the final codes and categories, whilst MH and JS confirmed the analytical themes. During the analytical process MH read the reports in which the category system was presented, and the meaning units were assigned to codes and category. MH also examined the data to explore if any items had been systematically or randomly excluded or if irrelevant items had been included (Graneheim & Lundman, 2004). During the final process, in which the two categories were merged into one, MH and ALH examined the data independent of each other. Out of a total of 43 meaning units, six were excluded while five in each group were rated differently and coded after joint decisions.

The observations and examples illustrated through case extracts are secondary data sources to the focus groups. The examples serves to exemplify what happens in network meetings and how the findings from the focus groups can be reflected in clinical situations. To find case extracts that could illustrate findings from the focus groups, the third network meetings in all 14 cases were listened through by ALH in order to remember and recall the cases. ALH also listened to the brief audiotaped field notes that were sometimes carried out after the meetings in order to explore if a particular network meeting possibly could contain passages of interest. Then, some cases were more closely explored in order to identify passages that were particularly suited to illustrate focus group findings. The selected examples are highlighted because of their clarity as to illustrate the findings of the focus groups concerning the dialogical approach.

The goal by including the more general yet clear observations is to confirm or add more nuanced information to the findings from the focus groups from another angle, i.e. real network meetings. The observations highlight our overall impressions from the network meetings concerning topics discussed in the focus groups. The included observations represent striking features, which were acknowledged by the participants and identified and discussed during the project period.

Results

The findings reported her focus on the group discussions' relating to what promotes or impedes dialogue in inter-agency

network meetings and how this is related to their professional backgrounds. To illuminate the results, some observations and examples from network meetings are included. To illustrate the professionals' opinions, some quotations from the focus groups are included together with a summary of the discussion connected to each code. Each focus group's quotations are referred to as either HCG (Health Care Group) or SEG (Social and Educational Group) and the particular informant by a number (SEG/1). The helpers in the network meetings are referred to as H (helper), the particular helper by a number (H1) and the help-seeker as HS.

The significance and challenges of listening

The professionals emphasized that they found it important to create an atmosphere in which all participants could start listening to each other in an active way. The social and educational group claimed that if they were able to acknowledge the significance of spoken and unspoken messages, this would provide the help-seeker with a sense of being taken seriously. Following this, the whole network meeting would be influenced by an atmosphere that contributed to the genuine participation of its members. However, personal competencies are needed to attain the potential inherent in nonverbal emphatic listening. As one participant noted:

> It has to do with insight and maturity. It has to with the ability to really put yourself in their place and understand. [SEG/3]

The healthcare professionals claimed that the meetings could help to ensure that the participants could improve their ability to listen to each other in situations where they previously had been placed in a defensive position in relation to each other. They also emphasized that through listening they got:

> A hold of where the vulnerability and the emotionality and the understanding of the story are. [HCG/2]

Another aspect for the social and educational workers was to not be afraid of silence and to be aware of how their focus on themselves might impair their ability to listen to others. Moreover, sometimes the professionals, regardless of sector affiliation, did not respect the time it took to really listen to the different perspectives. Instead of spending time dwelling on these perspectives, they went too quickly on to attempt to create solutions.

In a meeting held in an agency in the social and educational sector, the team consisted of a representative from the social and educational sector (H1), a healthcare worker (H2), the help-seeker (HS) and the help seekers mother (M) were present. During the meeting, the mother expressed strong emotions. This was followed up by reflection based on the team's listening to what she had to say before they again turned to the help-seeker:

> H1: What makes you want to steal things?
> HS: That's totally a good question.
> Silence (6 sec.)
> H1: It could be explained by you having use for it, but that's really something else.
> M and HS argue
> H1: Now we're going a little too fast. You said it was a good question. Can you talk a little bit with yourself?
> HS: I take things I can't afford. If I could choose between stealing and speed and excitement I would choose offshore racing.
> H2: Is offshore racing impossible?
> HS: It's so expensive!
> H2: But if you repair the boats yourself?

This example suggests how a dialogue may contribute to promote the help seekers self-reflection and be an opportunity for them to understand their actions. The professionals' opportunity to explore the situation in depth is interrupted when they break the silence and provide the help-seeker with solutions. The observations made by the first author confirmed that facilitating for a slowly developing process, including the absence of quick solutions, represented a common challenge for the professionals.

Authenticity versus techniques

A core element in OD is the facilitation of transparency through the professionals' open sharing of their thoughts and emotions with each other and with the help seekers. The aim is to generate new perspectives, develop a joint dialogue and promote authenticity (Seikkula, 2000).

When the healthcare workers discussed authenticity they mainly discussed this in terms of reflections with colleagues and emphasized the need for self-disclosure:

> If you just reflect to be so clever and not venture to say. . . what it is that I see, how does it feel, then maybe there's no reason to do it. . .? [HCG/1]

During the meetings with a help-seeker and his mother, the team consisting of two healthcare workers participated (H1 and H2). The meetings were held at home. The meeting started with the help-seekers' description of his relationship with his father, followed by a reflection by the team:

> H1: I became so tired when I heard the story about Dad and his anger. They can't even get angry any more. I felt like I lost all my energy.
> H2: You did?
> H1: Yes. And I wonder; is that the way Mom and HS experience it? Does he manage to take from them all their energy to fight for themselves?
> H2: I have rarely heard the son sigh like that.
> H1: Yes, I sat and watched him, too. He's like a deflated balloon. When did you observe his impatience? Can you say what it was connected to?
> H2: It was when Mom described Dad, I think. I got some thoughts that he's ready to go on. It was a moment... I was hoping for that, maybe that's what it was.

The extract is an example of a reflection characterized by professionals talking to each other about joint observations, the unspoken included, and who disclose personal thoughts, feelings and physical reactions. Furthermore, the professionals seem to be aware of their own emotions and how they can be presented in a way that promotes dialogue. Observations from the network meetings showed that this was often the case for professionals representing the mental healthcare sector. The social and educational personnel also focused on personal courage, but seemed less experienced in how to present the ideas they had about the situation without this being perceived negatively by the help-seeker:

> It's obvious that I, think. . . . . .such and such, but it's not always that I say it, because then it's scary. [SEG/2]

Another informant responded:

> I don't mean that you should say that you think it's going to be a failure, at the same time this way of working means of course being open about some of the thoughts you have. (. . .) That was that then. [SEG/1]

The professionals claimed that they found reflection to be an important tool, yet they also complained about professionals who refused or were reluctant to take part in this. The observations confirmed this; some professionals really seemed to prefer reflections while others never took part in this process at all.

Moreover, the healthcare workers emphasized that their reduced ability to take the lead could be a challenge:

> That of course is what it's all about (. . .) not to take over and have control and such. [HCG/5]

While the healthcare professionals found their major challenge within a mutual dialogue, the others seemed to search for particular techniques outside the dialogue:

> How do we like turn on the switch so that he can use the resources he has. . ..I think that maybe there are techniques for that. [SEG/1]

During the focus group interviews these professionals also referred to their chances of offering special techniques, such as supervision and advice.

Discussion

Our aim in this paper was to explore what professionals regard as important skills and attitudes for generating inter-agency network meetings: More specifically, we wanted to examine the professionals' understanding of the factors that promote or impede dialogue in inter-agency network meetings and how this is related to their professional backgrounds.

The findings suggest that the professionals considered the meeting atmosphere to be a significant factor for promoting dialogue. An atmosphere based on active listening was perceived as a catalyst for genuine participation among all members of the network. This was in turn seen to generate more authentic representations of how the participants perceived their situation and their responsibility for improvement. The professionals' ability to listen actively and speak openly seems to be an important factor leading to increased integration of common goals, a sense of mutual interdependence and a shared team identity.

The professionals' ability to listen actively and respond authentically may be challenged because of role blurring through role release and role expansion. This can lead to a sense of insecurity, which can be heightened, with the inclusion of the private network (Holmesland et al., 2010). In teams involving professionals with different understanding of how the concepts of OD and particularly the team processes should be understood, a shared team identity may be difficult to achieve. Other findings from this study indicate that some professionals in Project Joint Development developed a professional identity that places much focus on the integration and the ability to achieve role expansion while others had less focus on these aspects. The results indicated that they had a different development of professional identity (Holmesland et al., 2010). Followed by this, it may be a challenge to carry out inter- and intraprofessional teamwork in inter-agency network meetings. Lack of integration and a shared team identity may lead towards intra and interprofessional inter-agency collaboration.

The importance of involving the private network is illustrated in a study where the findings showed that open discussions among the participants may improve relationships and shared understanding followed by increased safety (Piippo & Aaltonen, 2008a). Likewise, if the professionals were able to talk about their own thoughts in an open manner, this increased the openness between the participants (Piippo & Aaltonen, 2008b). Previous findings from Project Joint Development indicates that personal familiarity with team partners including an understanding of how their personal thoughts and feelings will be received by them, may contribute to increased safety and thus greater authenticity among the professionals (Holmesland et al., 2010). In a study by Suter et al. (2009) the findings showed that the team members felt it important to represent a unified opinion in meetings involving the help-seekers and their families. The OD approach may represent special challenges when it comes to communicative aspects because of the aim to facilitate the emergence for different and also contrasting, perspectives. The professionals' joint education should increase their awareness of these challenges and facilitate attitudes and skills in promoting joint dialogues involving participants who are able to reach a common understanding based on different perspectives.

The findings illustrate challenges for all professionals' in dwelling on specific topics while the social and educational professionals also mention dealing with silence as potentially demanding. Both aspects illustrate the basic idea of OD. The professionals aim to listen to and follow-up the help-seekers' utterances and thus dwelling on specific topics and silence provides the possibility for the participants to contemplate, acknowledge and respond to particular utterances. Dwelling and silence may be perceived as challenging because of the courage needed to delay apparently effective actions in a hope to achieve even better results in the future. The significance of silence is confirmed in a study on the implementation of OD in an outreach team in which silences were seen to contribute to making the OD collective. Instead of making immediate decisions, the silence creates opportunities for the various perspectives to be negotiated (Søndergaard, 2010). Thus, listening, dwelling and silence represent non-standard forms of professional behavior, and hence it is likely that achievement of these factors most often will occur in well integrated teams with a shared team identity.

The findings indicate that the professionals may experience the skills and attitudes connected to dialogue in network meetings as challenging. The observations of network meetings indicate that particularly mental health care professionals seemed to be more focused on the dialogical processes, but variations also existed within the other groups of professionals. Although professionals representing the social and educational sector seemed to stress and to be more stressed by the network's demand for concrete solutions, some professionals, particularly some educational workers were adept at facilitating slowly developing dialogues. Because OD emphasizes some personal attributes, some professionals may find that OD is a good match for them-selves personally. Thus, the variability connected to behavior within the different groups of professionals may also occur because of personal differences rather than socialization into professions or agencies. In a previous paper about Project Joint Development, the findings indicate that the professionals place the healthcare workers in a somewhat more important position than the professionals representing the social and educational sectors pointing out that the healthcare workers representing the medical paradigm (Holmesland et al., 2010). This may indicate that the professionals lack both knowledge of and trust in the potentially curative effect of a dialogical approach. Instead, they may emphasize the need for other skills provided by professionals working in health care agencies. Hence, achieving intra- and interprofessional inter-agency teamwork in network meetings may be a challenging task.

This study has some limitations. The sample represents a great variation in professionals and agencies, which provides us with great diversity in the information. However, this diversity means that the dialogues held in the focus groups may have produced different information because of the different affiliations and

attitudes linked to each professional (Bloor et al., 2001). These differences may have been reinforced as the project was initiated by the local hospital and managed by the agencies involved. As the first author became more familiar with the participants as the project went on, this may have affected the information, in negative or positive directions.

Conclusion

By participating in inter-agency network meetings, the professionals acquire awareness concerning skills and attitudes to promote dialogues within a network of people of mutual significance for each other's well-being. Having focus on factors which may contribute to joint dialogues, such as seeing the significance of listening, silence and authenticity, increases the professional's ability, and thus the healthcare system's in general, to create need-adapted solutions to complex problems. However, there is a need to address the following: emphasize the meeting atmosphere as a significant factor because of its influence on the participants' ability to listen and speak openly; be aware of the importance of dwelling on important issues and tolerate silence as this may provide the network with space to open up for new perspectives; be aware of the significance of professional authenticity and how authentic reflections can be presented in a way that promotes personal growth.

We believe that the findings generated in this explorative study are of relevance for others who are aiming to implement inter-agency social network interventions involving intra- and inter-professional teams. The findings may have implications for clinicians', educators' and researchers' knowledge of what professionals consider to be important skills and attitudes in network meetings. The findings have generated areas for further investigation, including how professionals may dwell on specific topics, promote silence, and venture into greater authenticity in a way that will help to promote relationships and produce new perspectives.

Acknowledgements

The authors would like to thank the informants for sharing their experiences and editor-in–chief for useful comments on earlier versions. We want to thank Soerlandet Hospital Trust and Oslo University Hospital, Child and Adolescent Mental Health Research Unit for funding the study.

Declaration of interest

The authors report no conflicts of interest. The authors alone were responsible for the content and writing of this paper.

References

Billow, R.M. (2010). Models of therapeutic engagement part II: Sincerity and authenticity. *International Journal of Group Psychotherapy*, *60*, 29–58.

Bloor, M., Frankland, J., Thomas, M., & Robson, K. (2001). *Focus groups in social research*. London: Sage.

Brottveit, Å. (2013). Åpne Samtaler - mer enn ord? Nettverksmøter som kommunikative hendelser, kunnskapsproduksjon og sosial strukturering. (PhD thesis, Universitetet i Oslo, Norway).

Doyle, B. (1997). Transdisciplinary approaches to working with families. In B. Carpenter (Ed.), *Families in context: emerging trends in family support and early intervention* (pp. 150–163). London: David Fulton.

Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*, 105–12.

Guregård, S. (2009). *Open dialogue across cultures: Establishing a therapeutic relationship with the refugee family* (PhD thesis, University of East London, England).

Halkier, B. (2002). *Fokusgrupper*. Denmark: Samfundslitteratur & Roskilde Universitetsforlag.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care, 1*, 188–196.

Holloway, V. (2009). *The Valdres project: A study of perceptions and experiences with network meetings, including mental health clients, social network members and professional staff members*. Oslo, Norway: Norwegian Institute of Public Health.

Holmesland, A.-L., Seikkula, J., Nilsen, Ø., Hopfenbeck, M., & Arnkil, T.E. (2010). Open Dialogues in social netwoks: professional identity and transdisciplinary collaboration. *International Journal of Integrated Care*, *10*, 1–14.

Holmesland, A.-L., Seikkula, J., & Arnkil, T.E. (forthcoming). Transdisciplinary collaboration and role release in Open Dialogue with adolescents' social network. Unpublished manuscript.

Horwath J., & Morrison, T., (2007). Collaboration, integration and change in children's services: Critical issues and key ingredients. *Child Abuse & Neglect*, *31*, 55–69.

Hummelvoll, J.K. (2008). The multistage focus group interview. *Norsk Tidsskrift for Sykepleieforskning*, *10*, 3–14.

Kohlbacher, F. (2006). The use of qualitative content analysis in case study research. *Qualitative Social Research*, *7*, 1–30.

McGonigel, M.J., Woodruff, G., & Roszmann-Millican, M. (1994). The transdisciplinary team. A model for family-centered early intervention. In L.J. Johnson, R.J. Gallagher, M.J. LaMontagne, J.B. Jordan, J.J. Gallagher, P.L. Hutinger, & M.B. Karnes (Eds.), *Meeting early intervention challenges. Issues from birth to three* (pp. 95–131). Baltimore: Brookes Publishing.

McLean, S. (2012). Barriers to collaboration on behalf of children with challenging behaviours: a large qualitative study of five constituent groups. *Child & Family Social Work*, *17*, 478–486.

Ødegård, A. (2005). Perceptions of interprofessional collaboration in relation to children with mental health problems. A pilot study. *Journal of Interprofessional Care*, *19*:347–357.

Piippo, J., & Aaltonen, J. (2008a). Mental health and creating safety: The participation of relatives in psychiatric treatment and its significance. *Journal of Clinical Nursing*, *18*, 2003–2012.

Piippo, J., & Aaltonen, J. (2008b). Mental health care: Trust and mistrust in different caring contexts. *Journal of Clinical Nursing*, *17*, 2867–2874.

Reeves, S., Lewin, S., Espin, S., & Zwarenstein M. (2010). *Interprofessional teamwork for health and social care*. Oxford: Blackwell Publishing.

Seikkula, J. (2000). *Åpne Samtaler*. Oslo: Tano Aschehoug.

Seikkula, J. (2008). Inner and outer voices in the present moment of family and network therapy. *Journal of Family Therapy*, *30*, 478–491.

Seikkula, J. (2011). Becoming dialogical: Psychotherapy or a way of life? *The Australian and New Zealand Journal of Family Therapy*, *32*: 179–193.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, *16* 214–228.

Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The comprehensive Open-Dialogue approach in western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis*, *3*, 192–204.

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care*, *23*, 41–51.

Søndergaard, K.D. (2010). *Innovating mental health care* (PhD thesis, Aarhus University, Denmark).

Thylefors, I. (2012). Does time matter? Exploring the relationship between interdependent teamwork and time allocation in Swedish interprofessional teams. *Journal of Interprofesssional Care*, *26*, 269–275.

Thylefors, I., Persson, O., & Hellström, D. (2005). Team types, perceived efficiency and team climate in Swedisch cross-professional teamwork. *Journal of Interprofessional Care*, *19*, 102–114.

Thylstrup, B. (2009). *Dual diagnosis and treatment relations* (PhD thesis, Copenhagen University, Denmark).

Willumsen, E. (Ed.). (2009). Tverrprofesjonelt samarbeid i praksis og utdanning i helse- og sosial sektoren. In *Tverrprofesjonelt samarbeid i praksis og utdanning* (pp. 16–32). Oslo: Universitetsforlaget.

Yin, R.K. (2014). *Case study research. Design and methods*. London: Sage.